DOCUMENT RESUME

ED 463 462 CG 030 836

AUTHOR	Bullard, Bonnie; Lawless, Linda; Williams, Midge; Bergstrom, Deborah
TITLE	Mental Health Counselor's Clinical Practice Companion: A Continuing Education Program.
INSTITUTION	American Mental Health Counselors Association, Alexandria, VA.; Professional Training Inst., Sudbury, MA.
ISBN	ISBN-0-7872-6386-9; ISBN-0-7872-6385-0
PUB DATE	1999-00-00
NOTE	306p.; Appended are the Assessment Questions.
AVAILABLE FROM	Kendall/Hunt Publishing Company Customer Service, 4050 Westmark Dr., P.O. Box 1840, Dubuque, IA 52004-1840 ($225). Tel: 800-338-8290 (Toll Free).
PUB TYPE	Books (010) -- Guides - Non-Classroom (055) -- Tests/Questionnaires (160)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Counseling Techniques; Counseling Theories; *Counselors; *Home Study; *Independent Study; Licensing Examinations (Professions); *Mental Health Workers; *Review (Reexamination)
IDENTIFIERS	Diagnostic Statistical Manual of Mental Disorders; Psychopharmacology

ABSTRACT

Lifelong learning is a major challenge for today's professionals. This home-study learning program offers a cost-effective means that allows learners to pace themselves in learning a body of knowledge in relation to their individual needs. A self-assessment questionnaire allows readers to assess their strengths and weaknesses in relation to the ongoing knowledge needed in comprehensive clinical mental health counseling. It provides a comprehensive review of theory and practice and answers questions that arise in the course of practice. The review begins with the fundamentals on theories of growth and development and has several chapters on direct clinical material, such as assessment; diagnosis; counseling modalities; and treatment planning. It also includes information on the mental status examination content and the history of the Diagnostic Statistical Manual system. Special treatment areas such as suicide; domestic violence; abuse; incest; treating particular populations; and psychopharmacology are detailed in separate sections. Research and evaluation and statistics and outcome studies are reviewed as a growing focus in all practice management. An assessment booklet containing a study log; a self-examination; an envelope to mail the exam for scoring and credit; and a program evaluation form accompany the manual. (Contains over 290 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 463 462

Mental Health Counselor's Clinical Practice Companion: A Continuing Education Program

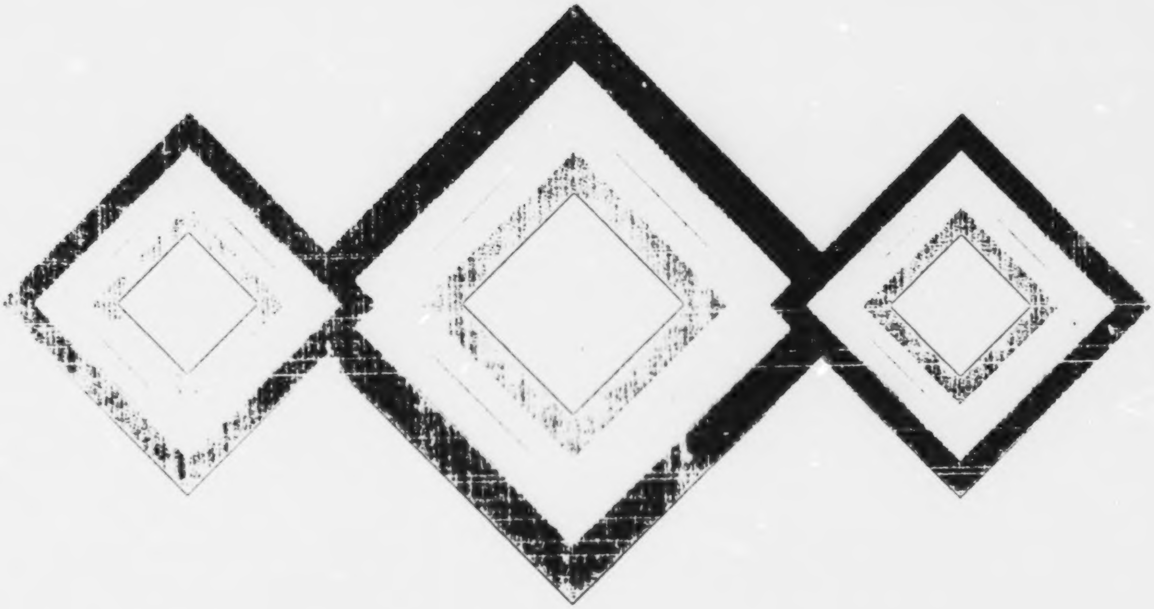
Bonnie Bullard, Linda Lawless, Midge Williams, and Deborah Bergstrom

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
B. Bullard
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
2B

CG 030 836

BEST COPY AVAILABLE



Bonnie Bullard, Ph.D., LMHC
Linda Lawless, M.A., LMFT, LMHC
Midge Williams, M.A., LMHC
with Deborah Bergstrom

CG030836

Professional Training Institute
P.O. Box 393
Sudbury, MA 01776

American
Mental
Health
Counselors
Association

BEST COPY AVAILABLE

MENTAL HEALTH COUNSELOR'S CLINICAL PRACTICE COMPANION

◆ ◆ ◆

A Continuing Education Program

Bonnie Bullard, Ph.D., LMHC
Linda Lawless, M.A., LMFT, LMHC
Midge Williams, M.A., LMHC
and Deborah Bergstrom

Professional Training Institute
PO Box 393
Sudbury, MA 01776
617-576-8877 • 888-201-1619

AMHCA
American
Mental
Health
Counselors
Association

KENDALL/HUNT PUBLISHING COMPANY
4050 Westmark Drive Dubuque Iowa 52002

BEST COPY AVAILABLE

Copyright © 1999 by Professional Training Institute

ISBN 0-7872-6385-0

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the copyright owner.

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

BEST COPY AVAILABLE

TABLE OF CONTENTS

Introduction v

How to use this program vi

Content Areas

1. Growth and Development 3

Heredity vs. Environment • Sensitive Periods • Clinical Issues • Cognitive Development Theories • Other Factors: Language Development • Age and Life Span • Gender Effects

2. Personality and Social Development 9

Theories of Personality Development • Moral Development • Other Issues: Attachment • Sex Role Development • Family Factors • Age Factors

3. Assessment 21

The Role of the Clinician • Types of Tests • Ability Testing • Personality Testing • Projective Tests • Behavioral Assessments • Family Assessments • Values Assessments • Aptitude Tests • Achievement Tests • Career Assessment Instruments • Self-Concepts Personal Constructs and Self-Reports • Common Terms

Mental Status 43

Client Evaluation • Psychological Interview • Mental Status Examination • The Clinical Report • Mental Status Assessment Worksheet

4. Diagnosis 53

DSM-IV: History • Definition of a Mental Disorder • Description of Axes I-V • Other Concepts Used in Diagnosis • The 17 Diagnostic Categories of Axis I, Axis II, and Axis I—Not Mental Disorders • Summary of Key Changes from DSM-III-R • 10 Steps to Diagnosis

5. Treatment Planning 81

Theoretical Approach, Treatment Techniques, and Medication Used for Each Diagnostic Category on Axis I • Theoretical Approach, Treatment Techniques, and Medication Used for Each Diagnostic Category on Axis II

6. Counseling Theories 115

Psychodynamic Psychotherapies • Behavior Therapy • Cognitive-Behavioral Therapy • Humanistic Therapies • Reality Therapy • Transactional Analysis • Existential Psychotherapy

Family Therapy 121

Definition of Family Therapy • The Development of Family Therapy • Objectives of Family Therapy • Major Contributors to Family Therapy • Types of Family Therapists • Major Indications for Family Therapy • Techniques in Family Therapy

Group Therapy 134

History • Advantages of Group Therapy • Types of Groups • Leaders in the Field • Group Leadership Skills

7. Treatment Modalities 147

Family Therapy • Group Therapy • Individual Therapy • Crisis Intervention • Conflict Resolution/Mediation

8. Special Treatment Issues 151

Child Abuse and Neglect • Domestic Violence • Suicide • Counseling Specific

6

Populations: Counseling Elderly Populations • Minority Group Clients • Clients with Physical Disabilities • Lesbian and Gay Clients • Gender Issues

9. Substance Abuse 161

History • Definitions • Diagnosis • Differential Diagnosis • Dual Diagnosis • Stages of Substance Abuse • Treatment • Specific Substances

10. Psychopharmacology 185

Introduction • Important Concepts • Psychiatric Drugs: Antipsychotics Major Tranquilizers and Neuroleptics • Minor Tranquilizers-Anxiolytics • Antidepressants • Mood Stabilizers • Sedatives-Hypnotics • Barbiturates • Ethyl Alcohol • Opioid-Analgesics • Amphetamines • Methylphenidate • Cocaine • Hallucinogens and LSD • Professional/Clinical Issues

11. Research and Evaluation 205

Research Design: Research Process • Research Design Concepts • Kinds of Research • Research Strategies • Threats to Validity • Group Designs • Single-Subject Designs

12. Statistics 211

Descriptive Statistics • Inferential Statistics

13. Outcome Studies 219

Overview of Outcomes Research • Therapeutic Alliance • Therapist Variables • Client Variables • Treatment Factors • Other Client Issues

14. Prevention 225

Primary Types of Factors: Risk Factors • Protective Factors • Other Factor Systems • Objectives of Prevention • Strategies of Intervention

15. Career Development 229

History • Integration into Counseling Practice • Career Theories • Leaders in the Field • Career Counseling Competencies • Computer Assisted Career Guidance Systems • Key Terms

16. Organizational Consulting 239

Ethics of Consulting • The Rights of Consultees • Organizational Development • Consultation Competencies • The Consultive Process

17. Professional Practice 245

Quality of Care • Unprofessional Conduct • Malpractice • Legal Ethical • Reporting • Referral and Consultation • Record Keeping

Bibliography 261

Index 271

INTRODUCTION

Mental Health Counselor's Clinical Practice Companion

Home Study Program

Mental health counselors live in a growing knowledge society. Our clients are better informed than they were five years ago, and they challenge us to stay abreast of changes in our field. Many of us are also required to participate in continuing education activities to maintain our licenses. As both clinicains and educators we believe this calls for a more thoughtful approach to lifelong professional learning. Working, learning, dialogue, and collaboration become intimately intertwined as we grow professionally.

Lifelong learning in one's profession is one of the major challenges for the worldwide knowledge society of the future. Home-study learning programs such as this are cost effective and allow the learner to pace themselves in relation to their lifestyle. This approach also suits the adult learner by providing a body of knowledge that they can review based on their particular interests and needs. As you complete the self-assessment questionnaire you will discover your strengths and weaknesses in relation to the larger body of knowledge needed for comprehensive clinical mental health counseling.

About this Program

The ***Mental Health Counselor Clinical Practice Companion*** was developed by Licensed Mental Health Counselors, who were both practitioners and counselor educators, to meet multiple needs in the mental health counseling field.

The ***Clinical Practice Companion*** was designed to be useful to Professional Counselors as a continuing education home study tool that could become an integral part of their professional library. The ***Clinical Practice Companion*** provides a comprehensive review of theory and practice and answers many everyday questions that arise in the course of our work in the mental health field. It represents the latest research, and provides a broad spectrum of various and, sometimes, conflicting views in the field. The broad scope of content areas collected and organized together in a single volume is cost and time efficient. The extensive bibliography enables you to do additional research on questions you may have, or to help you obtain further information.

Each chapter of the ***Mental Health Counselor's Clinical Practice Companion*** presents an overview and summary in a comprehensive review of the major topics necessary to clinical mental health counseling practice today. We begin with an overview of the

BEST COPY AVAILABLE

fundamentals - theories of growth and development and theories of personality and social development - to provide context and underpinnings for direct, applied clinical material.

The several chapters on direct clinical material: assessment, diagnosis, counseling modalities and theories, and treatment planning are much more detailed and inclusive, providing the backbone of the clinical material that forms the basis of daily clinical practice. These chapters provide information outlining assessment processes and assessment materials, the mental status examination content and process, the history and framework of the DSM system, as well as summaries of all the Axis I and Axis II disorders. The treatment planning section provides information about the theoretical approach (es) used, treatment technique(s) used, and medication(s) for each diagnostic category. Again, for essential background knowledge, summaries of the major treatment modalities and the major counseling theories follow.

We then focus on three selected clinical areas for an even more detailed review: special treatment issues, including suicide, domestic violence, abuse, incest, treating particular populations, substance abuse, and psychopharmacolgy. These clinical areas are of particular importance in practice today.

Research and evaluation, statistics and outcome studies are then reviewed, as a growing focus in all practice management. Prevention, career development, and organizational consulting are reviewed as the next tier of practice information. Last, but by no means least important, is the section on professional practice, covered in considerable detail, as the comprehensive, responsible, legal and ethical framework for mental health counselor practice.

THIS HOME-STUDY PROGRAM CONTAINS:

- ***The Mental Health Counselor Clinical Practice Companion***
  (the text)
- A self-examination
  (to assess learning strengths and weaknesses, and to obtain CE credit)
- A study log
  (to plan your home study program and certify your work on the program)
- A program evaluation
  (to be returned with your examination)
- A pre-addressed return envelope
  (to submit your examination for scoring and credit)

Please check to see that all of these items are included in your program. If any part is missing, contact Kendall/Hunt Publishing Company, AMHCA, or PTI and we will send you the missing part immediately at no cost to you.

HOW TO USE THIS STUDY PROGRAM

We recommend you begin with the chapters that are of greatest interest to you. Study the chapter and answer the questions on the examination. The exam groups the questions by chapter, which makes it easy to coordinate with chapter review. Record your study dates and times on the Study Log. You can also use your study log as a goal setting tool. When you receive the program set a goal date for when you plan on completing that chapter. Mark this date on your personal/professional calendar to remind yourself that it is due. Commit to studying one chapter a week. Plan to complete the program within seventeen weeks or less.

When you have completed the study program, send all of the following in the enclosed pre-addressed return envelope:

___ Your examination
___ Your signed study log
___ Your course evaluation

IMPORTANT INFORMATION

1. Your exam will be scored and the results mailed to you within 12 weeks.
2. You have a year to complete the program. If you do not complete the program within a year you will need to contact AMHCA to extend your completion dates.
3. If your exam score is below the passing score you will be notified of the score you received and the passing score required (70%). At that time you will have the opportunity to take a second assessment examination. There will be a $50.00 administration fee.
4. Once you have passed the examination you will be sent a continuing education certificate from AMHCA with your name, the date of your passing score, and the number of hours received for this program. (20 CEUs)

YOUR LIFETIME PROFESSIONAL LEARNING PROGRAM

Your professional education after graduate school and internships is in your hands. It is important that the learning events be planned rather than a quick response to a pretty brochure you receive in the mail.

Begin the creation of a lifetime learning plan by reflecting on which areas in this workbook you felt uninformed about. This book contains a comprehensive home study program for a mental health counselor. If there are weak areas in your learning, now is the time to plan to learn what you need to know.

Also ask yourself what your professional mission and goals are for your future. The goals of someone new to the field entering a job in a clinic are different from a seasoned practitioner who is in private practice. What kinds of learning experiences do you need to help you reach your personal definition of success?

The staff of PTI, and AMHCA want you to succeed in your profession. It is a win-win outcome. We hope this study program has expanded your horizons as well as served your continuing education needs. If there is any way we can make this a better program, please send your ideas to PTI at PO Box 393 Sudbury, MA 01776.

Bonnie M. Bullard, Ph.D., LMHC
Linda Lawless, MA, LMFT, LMHC
Midge Williams, MA, LMHC
Deborah Bergstrom

May, 1999

Content Areas

◆ ◆ ◆

Chapter 1	Growth and Development
Chapter 2	Personality and Social Development
Chapter 3	Assessment
Chapter 4	Diagnosis
Chapter 5	Treatment Planning
Chapter 6	Counseling Theories
Chapter 7	Treatment Modalities
Chapter 8	Special Treatment Issues
Chapter 9	Substance Abuse
Chapter 10	Psychopharmacology
Chapter 11	Research and Evaluation
Chapter 12	Statistics
Chapter 13	Outcome Studies
Chapter 14	Prevention
Chapter 15	Career Development
Chapter 16	Organizational Counsulting
Chapter 17	Professional Practice

BEST COPY AVAILABLE

CHAPTER 1

Growth and Development

HEREDITY VS. ENVIRONMENT

Heredity and Environment, the nature—nurture controversy has historically been one of the major issues in developmental psychology. Currently most theorists agree that development is neither entirely the result of either one's genes nor the environment. At the present time, discussion revolves around the relative contributions of these factors and the ways in which they interact.

1. Heredity

Heredity is not as well understood as environmental factors. It is difficult to separate the effects of each of these elements. Some heredity/genetic factors, however, are known to effect psychological growth and development. It figures in some major mental illnesses such as schizophrenia and mental retardation.

A. **PKU (Phenylketonuria),** which is caused by the presence of a single gene, is an inherited metabolic disease in which the body is unable to use the chemical phenylalanine. If this chemical accumulates in the body it can cause severe mental retardation unless controlled by diet.

B. **Tay-Sachs Disease** (caused by a recessive gene) is an inherited metabolic disorder occurring most often in Jews whose ancestry is a small area in Eastern Europe. This disorder causes increasing degeneration of the nervous system and the brain. Death usually occurs before the age of four years.

C. **Fragile X Syndrome** is an inherited disorder which causes a weakening or break on the X sex chromosome. This syndrome is the second most common identifiable cause of mental retardation in males (after Down syndrome). Males with this syndrome have long faces, big ears, and, as adults, large testes. Men, more than women, with this syndrome are likely to be severely retarded. Autistic behaviors and speech problems are also seen in people with this syndrome.

D. **Chromosomal Anomalies** are defects in the number or structure of chromosomes for example Down Syndrome and Turner's Syndrome.

1. **Down Syndrome** (Trisomy 21, Mongolism) is caused by the presence of an extra #21 Chromosome. Person's with this syndrome have a constellation of abnormalities such as retarded physical growth, flat face with short nose, protruding lower lip, small rounded ears, thickened tongue, broad hands and feet, stubby fingers, an increased susceptibility to illnesses, and lower than average IQ.

2. **Turner's Syndrome** affects only females. It results from the absence of an X chromosome. Some major characteristics of this syndrome are dwarfism, shield-shaped chest, infantile sexual development, webbed neck and lower than average IQ.

2. Environment

The environmental influences on development include both the physical and social domains.

A. **Physical Domain**

1. **The environment prior to birth** is very important. It is frequently the cause of below-average intellectual functioning. The causes include maternal infections, blood incompatibilities, chronic maternal conditions, chemicals in the fetal environment (i.e. alcohol, drugs), radiation, malnutrition, age of the parents and maternal stress (Sarason and Sarason, 1996).

2. **Difficulties at and after birth** include asphyxia and prematurity (birth three or more weeks before term - often low in birth weight - three lbs. or less). Damage to the central nervous system following birth may cause mental retardation. CNS damage include infections, blows to the head, tumors, asphyxiation, and poisons. Lead, arsenic, and mercury are the most common poisons leading to CNS damage (Sarason and Sarason, 1996).

B. **Social Domain**

Social influences can include the child's birth order, his/her role and experiences in the family, community, with peers, at school, the effects of his/her culture, society and interaction with his/her inherited characteristics.

SENSITIVE PERIODS

These are particular times in development when important learning is thought to occur, or is likely to occur. During these times a person is particularly sensitive to stimulation. In order to look more systematically at growth and development, including sensitive periods, organization principles have been developed by researchers. Some principles that help to organize our thinking about growth and development are the environmental-learning and the cognitive-structural orientations.

1. Environmental-Learning

The Environmental-Learning orientation "sees the child as passive, and malleable, heavily influenced (or formed) by the environment"..."(these) theorists prefer to regard development as a continuous process and to stress the continuities between animal and human, between child and adult"..."all knowledge derives from experience in the world: empiricism" (Gardner, 1978, pp. 17, 89). Major theorists: Ivan Pavlov, J. B. Watson, E. L. Thorndike, B. F. Skinner, Albert Bandura.

2. Cognitive-Structural

The Congnitive-Structural orientation holds that the child is an "active organism who constructs knowledge of the world"..."development consists of a set of discrete and highly distinctive stages"..."knowledge is acquired by constructive interaction between the human subject and the physical or social object: interactionism" (Gardner, 1978, p. 17, 89). Major theorists: Jean Piaget, Barbel Inhelder, Lawrence Kohlberg.

CLINICAL ISSUES

In order to make an accurate diagnosis and appropriately treat deviant or dysfunctional behavior it is important to:

1. Be knowledgeable about normal development

2. Consider appropriate age expectations

3. Be aware of the person's stage of development in the following areas:

A. Cognitive development

B. Emotional development

C. Personality development

D. Physical development

COGNITIVE DEVELOPMENT THEORIES

How do children come to know their world? We know there are differences in the way younger and older children get to know the world and that they solve cognitive problems differently. A number of approaches have been used to explain the variability in the cognitive processes of how learning takes place.

1. Environmental-Learning Theories

Environmental-Learning Theories hold that changes in thinking come from one's experience in the world. These theories emphasize the learning of specific associations between objects and events in the child's environment.

A. Classical and Operant (Instrumental) Conditioning

Classical conditioning was developed by Ivan Pavlov and is the linking of a stimulus with the response that is elicited (S-R). For infants, this begins with the reflex reactions which are linked to food. B. F. Skinner's Operant Conditioning (behaviorism) is based on an existing behavior (operant), which is then reinforced, allowing that behavior to be shaped. In the case of infants, the reinforcer may be imitating the child's verbalization. For older children, the reinforcer may be candy, a gold star, a special activity.

B. Social Learning Theory

As developed by Albert Bandura (1969, 1974), Social Learning Theory suggests that learning takes place by observing sequences of behaviors being engaged in by others (modeling) and later carrying out those behaviors that had been observed. In this theory it is believed that children do not form a separate response to all the observed behaviors, but represent to themselves a whole pattern of responses and their consequences. The child then attempts to reproduce the modeled behaviors. This theory is not applicable to infancy.

2. Cognitive-Structural

Cognitive-Structural theories see qualitative changes in thinking as resulting in cognitive growth. The Cognitive-Structuralist approach looks at structural or organizational changes in stages of thinking.

A. **Jean Piaget** is the best-known Cognitive-Structuralist. In Piaget's theory children learn by using their mental structures through adaptation and equilibration. Piaget considers the acquisition of knowledge to be deeply rooted in the biology of the organism. Acquiring knowledge is a continuous process, with assimilation and accommodation occurring perpetually, and schemes (mental structures) constantly changing. Piaget's basic tenants are:

1. **Assimilation** is the process of gaining new knowledge by absorbing it into existing schemes.

2. **Accommodation** is the process of gaining new knowledge by modifying an existing scheme to the new knowledge. Ex: A child attempts to understand new knowledge by using his/her current repertoire of cognitive schemes (assimilation). As the child begins to recognize that the information is new, he/she develops new ways of responding to the information (accommodation).

3. **Adaptation** is learning about the environment through cognitive growth using assimilation and accommodation.

4. **Equilibration** is the time when major break-throughs of understanding happen - when neither assimilation or accommodation dominates, but are in balance.

B. Piaget's Stages of Cognitive Development:

1. **Sensorimotor (Ages 0-2) The key accomplishment is object permanence.** The child perceives objects in the environment in terms of sensory information provided by the object and actions that can be performed on them. The child can differentiate self from others and can think of an object not actually present.

2. **Preoperational/Symbolic Thought (Ages 2-7) The key accomplishment is symbolic representation.** The child is able to use symbols (speech), and can engage in mental activities (operations), i.e., classify in more sophisticated ways, seriate, conserve, and can understand part-whole relationships or relational terms (e.g., bigger, lighter).

3. **Concrete Operational Thought (Ages 7-11) The key accomplishment is the knowledge that objects and states can be manipulated.** The child is capable of certain logic, can relate dimensions, can appreciate that some aspects of objects remain the same despite changes in appearance, and can classify elements into hierarchies.

4. **Formal Operations (Age 11) The Key accomplishment, reasoning, is based on verbal/logical statements.** The child can relate any element/statement to any other, can manipulate variables in scientific experiment, can deal with proportions and analogies, can construct whole systems of belief, can become actively engaged in the world of ideas, and can reflect on his her own activity of thinking.

C. **Jerome Bruner** emphasizes that enriched environments enhance children's learning and cognitive growth. Bruner's belief that language is the most important element in the development of logical thought differs from Piaget who believes that the most crucial element in logical thought is acquisition of operations. Headstart is based on Bruner's belief that enriched environments enhance children's learning and cognitive development. Bruner's Stages of Cognitive Development are:

1. **Enactive** (similar to Piaget's Sensorimotor Stage) The child interacts with the world, thereby learning from it. Interactions such as reflexive movements of sucking and kicking are learning events for the child.
2. **Iconic** (similar to Piaget's Preoperational Stage) learning is accomplished by using mental operations and images in the thought process.
3. **Symbolic** (similar to Piaget's Concrete and Formal Operational Stages) learning takes place through the use of symbols and logical operations.

OTHER FACTORS TO CONSIDER IN GROWTH AND DEVELOPMENT

1. Language Development

Language Development consists of learning the sound, order and meaning of language. **Phonemes** are the smallest units of sound (how language is composed.) **Syntax** is the way words are put together to form phrases, clauses, and sentences (the arrangements of words within an utterance and the relationship of utterances). **Semantics** is the relationship between the word and the environment (the meaning of any particular language). **Morphemes** are the smallest units of meaning ("bye", "up"). Gardner (1978, p. 175) describes normal language development:

A. **First Year** - babbling (approx. end of 1st yr. - "mama", "papa", "words" in isolation that appear to have meaning).

B. **Second Year** - holophrases-1 word ("doggie", "come"), duos (paired words).

C. **Third Year** - modulation of meaning (simple, appropriate sentences).

D. **Fourth Year** - correct, but noncomplex, language.

E. **Fifth Year** - language increasingly resembles adult models.

2. Effects of age and life span psychology

A. **Intellectual Abilities** that were learned mostly through education and experience in the world are believed to continue to improve into the 60's and beyond, for example, vocabulary, general information, and math skills. Abilities using skills such as abstract reasoning, conceptualization and attention may decrease after mid-life (Horn and Donaldson, 1980). Major decreases in intellectual abilities, however, are not generally found until the 70's (Kangas and Bradway, 1971). Lower test performance by older persons is often due to factors of sensory limitations, the person's own anxiety, tiredness, or not being interested in the test. The typical intellectual aging pattern is that the older person has higher verbal than performance scores. Researchers have found that intellectual performance drops significantly prior to death for all persons regardless of age (Riegel and Riegel, 1972).

B. **During Mid-Life** there may be some decrease in performance. Tasks needing coordination of eye-hand movements or speeded responses may decline during this time. However, for many people, creativity and productivity are often at their highest level in middle age (Turner & Pinkston, 1993).

C. **After Mid-Life,** other skills tend to decrease. Older adults may have difficulty in their long-term memory and speed of recall if the material to be recalled is not familiar to them or is irrelevant to their life. It has been found, however, that declines associated with aging can be reversed with appropriate training (Dennis, 1966).

3. Effects of gender

Effects of Gender - In Maccoby & Jacklin's (1974) review of the literature to that time, they found evidence of very few differences in cognitive development between males and females. There does, however, appear to be some differences beginning in the pre-adolescence years.

A. **Females** at age 10 to 11 scored higher than males on tests of verbal ability. It also may be that as adults, females continue to be more adept in verbal reasoning and word fluency (Schaie, LaBouvie, 1974).

B. **Males** scored higher than females on tests assessing visual-spatial skills, also about 10 or 11 years of age. A year or two later males began to score higher on math skills. As adults, males may continue to be more skillful doing tasks involving numbers and spatial relationships (Schaie, LaBouvie, 1974).

CHAPTER 2

Personality and Social Development

THEORIES OF PERSONALITY DEVELOPMENT

1. Sigmund Freud

A. Theory of Psychosexual Development

Freud's theory holds that personality development is the result of interactions between biological drives. He believes that early social experience consists of three structures: id, ego, superego. He also posits a basic drive, the libido, which is the source of energy of all three personality structures. It operates under the pleasure principal which is the psychic force that motivates people to seek immediate gratification of instinctual (id) impulses.

1. The **id** is present at birth and represents a person's unconscious source of motives and drives. The id also operates according to the pleasure principle to reduce tension.

2. The **ego** is the part of the personality structure that emerges at approximately six months of age and represents logic and reason. The ego mediates between demands of the id, superego and reality and operates under the reality principle seeking to satisfy id urges in socially acceptable ways. Through the ego perception, memory, problem-solving and judgment develop.

3. The **superego** incorporates parental and societal values and standards into the personality, resulting in the conscience. The superego censures and modifies unacceptable id impulses. The superego develops between ages four and five because of the inability of the ego to reconcile the divergent demands of the id, superego and reality. This dynamic produces conflict and leads to a state of psychic distress or anxiety. The unresolved conflict provides the basis for future psychopathology.

B. Instinctual Drives

Freud developed a theory to explain how instinctual drives interact with childhood experiences producing adult personality. This theory of psychosexual development holds that a child's sex drive centers on a different part of the body during each stage of development. Personality results from the ways in which conflicts between id urges and social restrictions are resolved. The failure to resolve a psychosexual conflict or excessive satisfaction at any stage of development results in fixation at that stage and the beginning of future psychopathology. Fixation is defined as incomplete or inhibited development at one stage and the person stays at that stage until the conflict is resolved.

C. Freud's Stages of Psychosexual Development

1. **Oral** (0-12 mo.)
   Basic conflict - weaning
   Result of fixation - dependence, gullibility, sarcasm, orally-focused habits, i.e., passivity, smoking, nail-biting, and eating.

2. **Anal** (1-3 yrs.)
   Basic conflict - toilet training
   Result of fixation - anal retentiveness, stinginess, selfishness, obsessive-compulsive behavior, anal expulsiveness, cruelty, destructiveness, messiness.

3. **Phallic** (3-6 yrs.)
   Basic conflict - the Oedipus Complex (son attraction to mother), or the Electra Complex (daughter attraction to father)
   Result of fixation - phallic character and sexual exploitation of others
   Successful resolution - identification with the same-sex parent and development of the superego.

4. **Latency** (6-12 yrs.) (sexual drives & strivings are muted, unexpressed, or "latent")
   Basic conflict - social skills
   Successful resolution: greater ego function, once-dominant drives (ie: aggression) sublimated into athletic, social or intellectual activities.

5. **Genital** (12+ yrs.)
   Basic conflict - Focus on sexual issues i.e., sexual identity
   Successful resolution: less dependency on parents, new objects found for satisfaction of dependent & sexual needs.

D. Major Defense Mechanisms

Defense mechanisms are mental strategies that operate unconsciously and are used to reduce anxiety and emotional conflict arising from the differing demands of the id, superego and reality. They serve to deny or distort reality.

1. **Repression** - rejecting from conscious thought (denying or forgetting) an impulse or idea that provokes anxiety - reaction to instinctual stimuli. It is considered the most basic and most important defense mechanism, because it is the goal of all other defense mechanisms.

2. **Denial** - refusing to see something which is a fact or true in reality - reaction to external danger.

3. **Displacement** - substituting a different object or goal for an impulse or motive being expressed. (e.g., identifying through fantasy the expression of some impulse or motive).

4. **Reaction Formation** - expressing a motive or impulse in a way directly opposite than originally intended.

5. **Projection** - avoiding conflict within oneself by ascribing motives to someone else.

6. **Rationalization** - providing a reason for a behavior thus concealing the true motive for the behavior.

7. **Compensation** - attempting to develop or overdevelop a positive trait to make up for a perceived limitation.

8. **Identification** - identification with a person or cause with the unconscious hope that one will be seen as successful or worthwhile.

9. **Introjection** - accepting another's values as her/his own.

10. **Sublimation** - acting out an unacceptable impluse in a socially acceptable manner.

11. **Regression** - retreating to an earlier, safer, stage of development and behaving in ways characteristic of that stage in order to avoid anxiety.

2. Neo-Freudians

A. **Erik Erikson** borrowed from Freud, but differences remain. Erikson stressed the role of social rather than sexual factors in personality development. He believes that each stage of development is characterized by a psychosocial crisis representing the conflict between the individual and society. Erikson also sees personality development as a process that continues throughout the lifespan.

1. **Erickson's Stages of Psychosocial Development**

   a. **Oral-Sensory** (0-12 mo.)
   Major Conflict - Trust vs. Mistrust
   Important Relationship - Primary Caretaker
   Successful Outcome - Trust and optimism

   b. **Muscular-Anal** (12-36 mo.)
   Major Conflict - Autonomy vs. Shame and Doubt
   Important Relationship - Parents
   Successful Outcome - Self-assertion, self-control and feelings of adequacy

   c. **Locomotor-Genital** (3-6 yrs.)
   Major Conflict - Initiative vs. Guilt
   Important Relationships - Family
   Successful Outcome - Sense of initiative, purpose, and direction

   d. **Latency** (6-12 yrs.)
   Major Conflict - Industry vs. Inferiority

Important Relationships - School and Neighborhood
Successful Outcome - Productivity and competence in physical, intellectual and social skills

e. **Adolescence**
Major Conflict - Ego Identity vs. Role Confusion
Important Relationships - Peers and Leadership models
Successful Outcome - Integrated image of oneself as a unique person

f. **Early Adulthood**
Major Conflict - Intimacy vs. Isolation
Important Relationships - Partners in friendship and sex
Successful Outcome - Ability to form close personal relationships and make career commitments

g. **Middle Adulthood**
Major Conflict - Generativity vs. Stagnation
Important Relationships - Shared labor and household
Successful Outcome - Concern for future generations

h. **Maturity**
Major Conflict - Integrity vs. Despair
Important Relationships - Humankind
Successful Outcome - Sense of satisfaction with one's life and the ability to face death without despair

B. Adlerian Psychology (Alfred Adler)

Adler holds that all behavior occurs in a social context. He believes that transcending interpersonal interactions is the development of the feeling of being part of a larger whole. Adler views humans holistically as being: creative, responsible, "becoming" as a person and moving toward fictional goals within the phenomenal field. He believes that a person's lifestyle is sometimes self-defeating because of inferiority feelings. A person with "psychopathology" is "discouraged", not "sick". The treatment task is to encourage the discouraged person to activate his/her social interest and to develop a new life-style through relationships, analysis and action methods.

C. Karen Horney

Horney broke with Freudian theory on the major issues of the influence of culture on the personality, the influence of "the here and now", and on feminine psychology.

1. **Influence of culture on personality and a focus on "the here and now".** Horney believes that neuroses are not generated by instinctual conflicts, but by specific cultural conditions which lead to disturbed human relationships. Freud believed anxiety was caused mainly by repression of sexual impulses. Horney's belief is that the frequency with which anxiety is generated by sexual impulses is largely dependent on the existing cultural attitude towards sexuality.

2. **Feminine Psychology.** Horney focused on feminine psychology, questioning Freud's belief that healthy women were biologically predestined to be submissive and masochistic. One of Horney's greatest contributions was in understanding women. She believed that women's behavior was the result of culturally enforced patterns. She held that the character structure of both women and men could be understood only as a product of cultural forces not as being genetically determined.

3. **Application of Horney's** theory in treatment is particularly useful in relieving women of psychological complications of culturally induced submissiveness, self-effacement and excessive dependency.

4. **The concept of the self is central to Horney's theory.**

    a. **actual self** - the sum total of the individual's experiences.
    b. **real self** - the central force or principle. It is unique within each individual and is equivalent to a sense of healthy integration or harmonious wholeness.
    c. **ideal self** - manifestation of neurosis. It serves as a means of avoiding psychic conflict by adopting an attitude of superiority or self-sufficiency or by demanding special consideration.

5. **Treatment emphasizes:**

    a. self-realization, self-actualization in dealing with the "here and now"
    b. activity of the analyst in the therapeutic process
    c. the emotional involvement between the therapist and patient as the most important aspect of the therapeutic process.

3. Carl Jung

Carl Jung studied with Freud, but later broke with him and elaborated his own theory of mental disorder called Analytical Psychology. The use of symbols is at the heart of Jung's theory. He believes symbols originate in the deep level of the unconscious, in the "objective psyche". These symbols are derived from the collective experience of the race - archetypal modes of thought. Jung believes that the realization of one's potential comes about through a gradual, laborious process of getting to know various facets of one's objective psyche. Many of Jung's concepts are part of psychiatric nomenclature and part of contemporary vocabulary:

A. **Archetypes** - a priori ordering principles for potential Gestalt, usually unconscious, but through the ages have given rise to similar forms of imagery.

B. **Extravert - Introvert** - the individual's source of energy is believed to be either the outer world of other people or the inner world of thoughts and ideas.

C. **Psychological types** - Categories of behavior based on our basic personality preferences. The Myers-Briggs Type Indicator uses Jungian theory.

D. **The Shadow** - the objective counterpart of the personal unconscious which represents some of the unacceptable aspects and components of the objective psyche.

E. **Anima and Animus** - combinations of personal and objective unconscious elements: anima - the feminine side of a man; animus - the masculine side of a woman.

F. **The Self** - at the very heart of the psyche; does not come into awareness until the person has succeeded in dealing with her or his Shadow and her or his anima or animus.

G. **The Persona** - official social mask or pattern of behavior that a person uses in social situations.

4. Object Relations Theory

Object Relations theory is seen as a reaction against the Freudian motivational concept of instinctual drives. Object Relations theorists believe that not only is "human behavior fueled by relational concerns, but also . . . the human psyche is fundamentally relational in nature" (Cashdan, 1988, p. 23). These theorists believe that in order "to understand what motivates people and how they view themselves, one needs to understand how relationships are internalized and how they become transformed into a sense of self" (Cashdan, 1988, p. 23).

"The term object relations refers to specific intrapsychic structures, to an aspect of ego organization, and not to external interpersonal relationships. However, these intrapsychic structures, the mental representations of self and other (the object), do become manifest in the interpersonal situation. That is, 'the inner world of object relations determines in a fundamental way the individual's relations with people in the external world'. The structural and dynamic relationships between the self-representation - the self - and the object-representations -the object- constitute what we refer to as object relations" (Horner, 1979, p. 3, 4).

The basic patterns between the self and the object (the first example is between child and major caregiver) evolve over the first three to four years of life and are the basis for ongoing mental configurations. In healthy development these intrapsychic structures continue throughout life, continually modified by experience. However, in pathological development they are organized in a rigid and distorted manner resulting in fixation at a pathological, infantile level of development in particular aspects of feeling, thinking, and behaving. The earlier the failure, the more pervasive and malignant the pathology. Certain kinds of disturbances are associated with developmental failure at certain stages or during transitional processes. With this developmental framework, one can understand both normal and pathological development, their consequences for adult character development and implications for the psychoanalytic treatment of the adult patient. Major Object Relations theorists are: Althea Horner, Otto Kernberg, Melaine Klein, W. R. D. Fairbairn, Margaret Mahler, Heinz Kohut, Blanck and Blanck.

5. Self-Actualization Theory

Abraham Maslow's theory of Self-Actualization holds the Ideal of Self-Actualization as the highest possible level of ego development. It is seen as the ability to use one's capacities to good purpose, to become fully absorbed in what one deems important and to do this in a lively, yet, selfless manner. Self-actualized persons are seen as fully human, capable of making choices. These persons choose to grow and are honest about their knowledge and limitations. They can accept responsibility and are willing to find out about themselves: who they are, what they like and dislike, what is good or bad for them, where they are going and what their mission in life is.

The special features characterizing the self-actualizer are:

A. **The Ability to Take Every Moment and Opportunity of Life Seriously** - to make the most of one's potential.

B. **The Capacity to Undergo Peak Experiences** - moments of ecstasy which are more likely to occur when one is honest with oneself, is willing to strive to realize one's potential, is capable of listening to others and when open for discovering what one is.

C. **Maslow's Hierarchy of Needs:** higher level needs come only when lower needs are largely satisfied, later in life (Bee, 1994):

Need for Self-Actualization

Esteem Needs
(Superiority and Respect, Including Self-respect)

Love and Belongingness Needs
(Affection from Others, Need to be with Others Rather than Alone)

Safety Needs
(Stable, Predictable Environment, Free From Anxiety and Chaos)

Physiological Needs
(Hunger, Thirst, Sex, Oxygen, Sleep, Elimination)

(Source: Maslow, 1968)

MORAL DEVELOPMENT

1. Lawrence Kohlberg

Lawrence Kohlberg was influenced by Piaget's concept of developmental stages. Kohlberg's theory holds that moral judgments are developed in sequences that cannot be changed. Each stage arises from the previous one and each is cognitively more complex than the previous stage. The levels and stages relate to the self and society.

Levels of morality:

Level 1 - Preconventional (4-10 yrs.)

In Stage 1, the orientation is on punishment-obedience. Moral judgment is based on the desire to avoid punishment.

In Stage 2, the orientation is on instrumental-relativism. Moral judgment is based on the desire to satisfy one's own needs and obtain rewards.

Level 2 - Conventional (10 - 13 yrs.)

In Stage 3, the orientation is on being "the good child". Moral judgment is based on the desire to avoid disapproval, to avoid the dislike of others, and secure interpersonal acceptance.

In Stage 4, the orientation is on law and order. Moral judgment is based on the desire to avoid censure by the legitimate authority.

Level 3 - Postconventional (adolescence - adulthood)

In Stage 5, the orientation is legalistic. Moral judgment is based on maintaining respect of others in the community, maintaining social order and valuing social contracts.

In Stage 6, the orientation is on universal ethical principles. Moral judgment is made within one's own conscience.

2. Carol Gilligan

Carol Gilligan worked with Kohlberg, later developing her own theory of moral development for females. She says that Kohlberg largely ignores an ethical/moral system based on caring for others, responsibility, altruism or compassion which includes more of the female's moral development. Instead, he focuses almost exclusively on the development of concepts of justice or fairness, more typical of males, not concepts of care. (Kohlberg's research population was exclusively male.) Gilligan maintains that women view relationships differently than men. Later research has shown that girls and women do use moral reasoning based on principles of justice when they are presented with dilemmas in which that is a central issue. Gilligan includes a much broader range of ethical stances than Kohlberg suggests.

OTHER ISSUES IN PERSONALITY AND SOCIAL DEVELOPMENT

1. Attachment

Attachment is the primary bond developed between an infant and primary caretaker. Particular behaviors maintain or increase the proximity between an infant and another person, for example: signaling behaviors (smiling, vocalizing), orienting behaviors, locomotion, active physical contact (clinging, hugging). Attachment is essential for infants.

A. **In Harlow's** (1958) research he found that monkeys reared in total isolation developed repetitious behaviors of rocking, self-clasping, lack of exploration, and other behaviors not much different from human schizophrenics. Monkeys raised with surrogate mothers were found to be less abnormal, but problems were evident. They had difficulties in establishing peer relationships, in participating in normal sexual activity, and in parenting their own offspring. Later research has found the negative effects of isolation and surrogate mothering can be, at least partially, reversed.

B. **Konrad Lorenz** (1937), in his work with imprinting found that ducklings follow the first object they see. He believed it was an adaptive function that keeps the young close to the mothers. He found a stronger bond with: 1. a stimulus that was large and moving 2. a stimulus that responded to the infant duckling with sound.

C. **John Bowlby** (1958), another major attachment theorist, emphasized the adaptive function of attachment: 1. closeness to food, 2. protection from predators, 3. opportunity for socialization. He proposed that human infants have behavioral systems ensuring development of attachment which increase the chances for survival, such as: sucking, crying, smiling, vocalizing, crawling, walking. If early attachment fails, there may be an inability to develop close social relationships. Bowlby also discussed the concept of separation.

1. **Bowlby's stages of attachment development:**

   a. Undiscriminating Social Responsiveness (0-3 months) Behaviors include: attachment behaviors, orienting behaviors (visual fixation), contact-promoting behaviors (grasping, smiling, crying).

   b. Discriminating Social Responsiveness (3-6 months) Behaviors include: distinguishing between family and non-family by differential smiling, crying, vocalizing.

c. Active Initiative in Seeking Proximity and Contact (6-30 months) Behaviors include: active proximity and contact-promoting behaviors of following and greeting.

d. Correct Partnership (30+ months) Behaviors include: predicting caretaker's behavior, developing methods for shaping caretaker's behavior toward the goal of developing attachment.

2. Concepts related to separation:

a. **Stranger Anxiety** - begins at approximately 8 months. Behaviors include crying, withdrawal and other fearful responses to strangers. These behaviors occur when the child has developed object permanence (is able to keep the caretaker in mind). When the caretaker is not present the child recognizes the difference between the known and the unknown which produces anxiety.

b. **Separation Anxiety** - begins at approximately 12 months. Fearful responses are displayed when the child is left by the caretaker. The appearance of these behaviors is related to the intensity of the child-caretaker attachment. It is part of normal development. In prolonged separation, Bowlby (1973) suggests that the child begins to adapt to the loss in progressive stages:

- Protest - child refuses to accept the separation by crying, screaming, kicking.
- Despair - child gives up all hope of being reunited and becomes quiet, inactive and withdrawn.
- Detachment - child begins to accept attention from others, recovers from her/his state of misery and may react with detachment and disinterest when visited by former caretakers.

c. **Anaclitic Depression** - Spitz (1946) found that institutionalized infants separated from their mothers in the first year of life and receiving minimal social contact developed "hospitalizms": retarded growth, poor physical health, high susceptibility to disease, and deficits in motor and cognitive development. Infants separated from their mothers for at least three months also displayed anaclitic depression. They evidenced listlessness, crying and withdrawal. The effects of institutionalization, however, could be reversed with consistent and frequent personal attention from substitute caretakers.

d. **Infantile Autism** - Children with infantile autism often do not have attachment behaviors such as eye contact, reaching, and smiling. They rarely initiate contact with caregivers and appear oblivious to others. They later fail to develop normal interpersonal relationships. The cause is not seen as parental deprivation, but one of heredity where certain physiological conditions pertain. (Knobloch & Pasamanick, 1974).

2. Sex Role Development

Sex Role Development (Sex Typing): The relationship between personality, behavior and gender. Approaches from the different theoretical orientations:

A. Biological

Factors in sex-role behaviors are unclear. Some theorists believe some sex differences appear before the environment has had a chance to make a difference. Examples include: newborn boys generally are more active than newborn girls - they cry more and sleep less (Maccoby & Jacklin, 1974). Sex-role differences may also be due to hormonal differences where the Y (male) chromosome creates more androgen in the brain during prenatal development.

B. Psychoanalytic

Freudian Theory. Gender-role identification comes from the Oedipus and Electra conflicts in the phallic stage of development (between 3 and 6 years of age). The child sees her/himself as a rival of the same-sex parent. Anxiety develops when the child recognizes the desire for the opposite sex parent won't be fulfilled. To reduce the anxiety, the child identifies with the same-sex parent and adopts that parent's behavior.

C. Social Learning

The development of appropriate sex-role behaviors is the result of gradual learning, beginning during infancy. The child's behavior is shaped by parents and others selectively rewarding and punishing appropriate or inappropriate behaviors of the same-sex parents and older siblings whom the child imitates.

D. Cognitive

The development of sex-role behaviors involves a sequence of stages dependent on the child's level of cognitive competence. By age two or three the child acquires gender identity, can label self as female or male and exhibits sex type toy preferences. By age four gender stability is established where the child knows a person remains female or male throughout life. By age six or seven the child has established gender consistency, knowing that sex is a permanent state that cannot be changed by changing appearance such as changing clothing. Sex-typed behavior is acquired by imitating same-sex models.

3. Family factors related to personality and social development

A. Parenting Styles play a role in a child's personality development. The interaction of permissiveness and affection on the part of the parents affects personality development (Schaefer, 1959):

1. **Love and Autonomy -** parents are loving and accepting - children tend to be independent, outgoing, active, assertive, tolerant, high in self-esteem.
2. **Love and Control -** parents are high in both affection and control - children tend to be dependent, insecure and low in creativity.
3. **Hostility and Autonomy -** parents are hostile and noncontrolling - children tend to be disobedient, aggressive, and rebellious.
4. **Hostility and Control -** parents are hostile and controlling - the children tend to be socially withdrawn, sullen, shy, and self-punishing (Baumrind, 1971).

B. Birth Order - first-borns (and only children) may be treated differently receiving more maternal attention and stimulation, and greater achievement orientation. This attention and stimulation may contribute to higher IQ scores for these children than later-born children.

C. Peer Factors become more formal and structured after about age 10, when the child's status in the peer group is more important. Popular children tend to be the youngest, rather than the oldest and to be more attractive, intelligent, and creative. They may have higher levels of self-control, self-confidence, mature dependence on other children and to have good social skills. Girls often focus on intimacy and shared feelings while boys focus on shared activities. Peer influence is greater in the areas of selection of friends, fashion, music and language fads. Parental attitudes continue to influence adolescents in moral and social values, future aspirations and political views.

4. Age Factors—The study of how changing priorities and experiences of age affect personality

A. Daniel Levinson Identified Major Transitions in Adult Life:

1. Early adult transition (ages 17-22)
2. Mid-life transition (ages 40-45)
3. Late adult transition (ages 60-65)

B. Levinson Postulates That There Are Three Developmental Tasks of Adulthood

1. To build, modify, and enhance one's life structure
2. To form and modify single components of the life structure, for example: life dream, occupation, love-marriage, family relationships, mentoring, forming mutual relationships
3. To become more individuated

C. Stages of Adulthood as Seen by Other Theorists:

1. **Early adulthood** (in the 20's) is seen by some theorists as being a time of looking outward to establish one's career, to marry or make life partnerships and to begin a family. Decisions made in one's 20's may become a source of conflict because of later re-evaluation of earlier decisions. The second half of early adulthood (28-34) may contain difficult transitions, i.e., end of partnership/marriage, change in career.

2. **Middle adulthood** may include mid-life transitions ("mid-life crisis") (Levinson, 1978). Between ages 35 and 45 may be a time of evaluation of the discrepancy between one's accomplishments and one's life goals. A person may experience a confrontation with personal limitations, with acceptance of the inevitability of aging and death as well as re-formation and re-prioritization of goals to be more consistent with reality.

3. **Late adulthood** studies on "successful aging" have found generally inconsistent results. Some agreement has been found where successful adjustment is related to a person's previous level of adjustment. Satisfaction has also been associated with self-esteem, financial resources, marital status and health. Personality has generally been found to remain stable into old age. Some characteristics have been found to be age-related. Introversion and cautiousness tend to increase during the second half of life. The major task of late adulthood is seen to be retirement; the primary factors of which are health and financial resources. Continued participation in pre-retirement activities (or substitute activities) is seen to be associated with successful retirement.

4. The most significant task of **Old Age** is facing death, one's own, the death of spouse/partner, family members and friends. Kubler-Ross believes that most dying patients pass through the stages of denial, anger, bargaining, depression and finally acceptance of death. Personal reactions to dying are affected by whether one is living in familiar and stable surroundings, in which case one is often less afraid of dying. Persons about to be admitted to a "home for the aged" are more afraid of dying. Elderly persons are generally less anxious about death than middle-aged people.

CHAPTER 3

Assessment

The term's assessment, appraisal and testing are often used to describe the same activity. For the needs of this chapter, they will all refer to the same process unless specified otherwise. Anastasi (1988) describes psychological testing as "an objective and standardized measure of a sample of behavior." Earlier forms of assessment were simply the clinical interview which included the patient's history and their current situation. Tests were developed to counter the subjectivity and variability of interview techniques. Current assessment takes many forms. Assessment can be diagnostic specific (Beck Depression Inventory) a structured interview or a complete neuropsychological battery. It is the job of the clinician to determine what is appropriate for each client.

THE ROLE OF THE CLINICIAN

Clinicians use a wide range of information to make decisions during their work. The assessment process begins with the first contact of the potential client. An assessment is made of the content as well as the process of the interactions. Formalized tests are one method of gathering information, and the scores that are generated are vehicles for creating hypotheses. Clinicians need to be aware of test construction, statistics and test interpretation. "The clinician should use all the objective test data and actuarial strategies applicable to the particular situation, while supplementing this information with facts and inferences attainable only through clinical methods", (Anastasi, 1988). Mental health counselors can administer and interpret any test they have had the education and experience needed to qualify them, unless the region in which they have practiced has current laws or legislation that prohibits their test administration.

1. Clinical judgment

A. Gathering Information

The development of rapport with the client increases the likelihood that accurate and honest information will be gathered. The clinician must also be aware of their responses to the client as information is obtained. Bias can enter into this dialogue from many different areas such as the clinician's theoretical

BEST COPY AVAILABLE

beliefs and personal life experiences. The more unstructured the testing is, the higher the possibility of bias entering the assessment outcome.

B. Interpreting the Data

The test outcome should be integrated into the whole picture of the client including etiology, systems of interaction, treatment recommendations and prognosis. Using the test outcomes the clinician can redefine the hypothesis about the client, the diagnosis, treatment plan and interventions or future prognosis.

2. The ethics of assessment

Clinicians must abide by the ethical standards of their professional association. Every counselor must also abide by the national and regional laws and legislation that relates to testing. A practicing clinician must maintain current accurate information pertaining to the ethics of assessment and abide by it. Ethical standards cover and are not limited to:

- Privacy and confidentiality
- Competencies required to administer tests
- Interpretation of test results
- Communicating test results
- Norms
- Validity
- Reliability
- Requiring that testing materials not be made available to the general public to ensure continued test validity

3. Test settings

Testing can be done in a number of settings. The following are examples and are not the only places assessment can be done:

- Clinician's office
- Client's home
- Referring professional's office
- Physician's office
- Hospital
- School
- Work
- Jail
- Clinic

The appropriateness of the setting and its impact on the test scores must always be considered.

4. Selecting tests

The first question must be how useful will this test be in answering a clinical question. The second question must be how qualified am I in administering this test. Also to be considered is the time needed in administration and cost. Testing appropriateness for the client must be considered. Will this test lead to other tests? How much can the client tolerate the testing process? Finally, do you have the clinical expertise to make all of these decisions or do you need professional consultation before making any decisions? Test resources are listed in:

- *The Mental Measurements Yearbook* (Kramer and Conoley, 1992)
- *Tests: A Comprehensive Reference for Assessment in Psychology, Education, and Business* (Sweetland and Keyser, 1991)
- *Measuring Mental Illness: Psychometric Assessment for Clinicians* (Wetzler, 1989)
- *Measures for Clinical Practice: A Sourcebook* (Corcoran & Fischer, 1994)
- *Tests in Print IV* (Buros, 1994)

A. Evaluating a Psychological Test

Before administering or referring a client for testing, the clinician must evaluate the appropriateness of the test. The following questions need to be considered (Groth-Marnat, 1997):

- Do I understand the theoretical construct the test is supposed to be measuring?
- Do the test items correspond to the theoretical description of the construct?
- Does the examinee's ability to read and understand match the level required by the test?
- How appropriate is the length of the test?
- Is the person/population to be tested similar to the population the test was standardized for?
- Was the standardization size sample adequate?
- Have specialized subgroup norms been developed?
- How adequately do the instructions permit standardized administration?
- Are reliability estimates high enough?
- What criteria and procedures were used to validate the test?
- Will the test produce accurate measurements within the context and purpose for which I would like to use it?

B. Psychological Assessment and Treatment Planning

Assessments are used to gather information to facilitate clinical decision making. The assessment outcomes must be integrated into the whole picture, sometimes referred to as case management, which includes but is not limited to the following:

- Developmental approaches
- Assessment tools designed to identify targeted diagnosis i.e., phobia, depression
- Refining intervention techniques based on assessment outcomes i.e., the extent of vegetative or manic symptoms
- Identifying what kind of therapy to use with a client
- Tailoring interventions around the stages of change; precontemplation, contemplation, preparation, action and maintenance

C. Treatment planning needs to consider:

1. The severity of the problem which can be measured with:
    - MMPI (Minnesota Multiphasic Personality Inventory)
    - Mental Status
    - DSM-IV Multiaxial Assessment

2. The level of motivation of the client
   - MMPI
   - BSI (Brief Symptom Inventory)

3. How complex the problem is
   - Number of DSM diagnoses
   - Pervasive or recurrent problem patterns

4. Pervasive personality disorder
   - MMPI
   - TAT (Thematic Apperception Test)

5. The level of client resistance to treatment
   - MMPI
   - MCMI (Millon Clinical Multiaxial Inventory)

6. The extent of the client's coping mechanisms and styles
   - MMPI
   - MCMI

7. The level of development in the change process
   - Stages of Change Scale

TYPES OF TESTS

Objective tests are usually true/false or multiple choice. They tend to have higher reliability than projective tests since their scoring is not subjective, or based on the opinion of the reviewer. Subjective, or projective tests, are usually essay, short answer tests. Answers are created as a result of exposure to a particular stimulus. Test administrators who use projective techniques, require administration and scoring training. Projective tests are thought to have lower reliability. What all of these tests seem to have in common is that they measure a sample of behavior/s, and they have a standardized procedure for gathering information and analyzing it.

A criticism of the use of tests in counseling focuses on the administration and interpretation process. Although the administration is usually well documented in the test manual, often there is a lack of instruction to the test provider on how to adequately interpret the results. It is generally found, that a cursory interpretation is provided with the test materials. There are many objective tests that can be given by a clinician and computer scored with an interpretive analysis of the data. However, the responsibility lies with the tester to understand the appropriateness and interpretability of the test being given, and how helpfully it is presented to the client.

1. The assessment interview and case history

"There are two interview styles used by mental health professionals: insight oriented (psycho-dynamic) and symptom-oriented (descriptive)" (Othmer & Othmer, 1994).

A. Insight Oriented

Based on the work of Sigmund Freud, the insight oriented belief is based on the experiences of the past unconsciously interfering with the client's current symptoms and pain. The goal of the insight oriented interview is to uncover these conflicts, bringing them into awareness. The role of the clinician is to not only help uncover these pathogens, but to help interpret their meaning. The interview serves a dual purpose of diagnosis and therapy. The key word for this methodology is "explains."

B. Symptom Oriented

Related to the DSM, this interview style clusters symptoms and behaviors into the clinical criteria required for a DSM diagnosis. Other information included is the client's coping skills, medical condition, stressors, psychosocial and environmental problems. The keyword for this methodology is "classifies."

C. Phases of the Interview

Phase 1 - Establishing Rapport

- Put the client at ease
- Find out where they are experiencing pain and show compassion
- Assess their ability to have insight
- Establish yourself as an expert
- Lead the interview
- Vary the role as needed by the client i.e., listener, expert, empathizer
- Insight oriented - transference and countertransference patterns are noted as the interview proceeds
- Symptom oriented - As trust is established more information will be brought forward

Phase 2 - Interview Techniques

- Insight oriented - Techniques used can be free association, confrontation and interpretation
- Symptom oriented - The focus is on signs, behaviors, objective and measurable symptoms

Phase 3 - Mental Status Assessment (MSA) The mental status examination is the primary intake assessment method used in many mental health settings. It is an assessment that is used by many clinicians when they first meet a client. The MSA is used to create a global view of the functioning of the client. The MSA has been called the psychiatrist's analog to the general physical examination. It is often used in an initial psychological report and as a global measure for outcomes. The MSA is available in both non standardized, more subjective and standardized, check-list types of formats. The MSA is an important assessment tool to become familiar with since it is well known across the profession and is often used when case material is presented by colleagues. A sample MSA follows this chapter.

Phase 4 - Diagnosis (DSM)

- Assessment of Axis I disorders
- Assessment of Axis II disorders
- Diagnostic focused interview models (Groth-Marnat, 1997)
- Anxiety Disorders Interview Schedule (ADIS)
- Diagnostic Interview for Borderlines (DIB)
- Psychopathy Checklist (PCL)
- Structured Interview for DSM-IV
- Dissociative Disorders (SCID-D)
- Structured Interview of Reported Symptoms (SIRS)
- Psychosocial Pain Inventory (PSPI)
- Comprehensive Drinker Profile (CDP)
- Eating Disorder Examination (EDE)

- Eating Disorder Inventory-2 (EDI-2)
- Structured Interview of Sleep Disorders (SISD)
- Substance Use Disorders Diagnostic Schedule (SUDDS)
- Schedule for Affective Disorders and Schizophrenia (SADS) - Adult version and Child version
- Diagnostic Interview Schedule (DIS) - Child version (DISC)

Phase 5 - Multiperspective evaluation

a. History of the Problem
  - Description - intensity and duration
  - Date of onset
  - Changes
  - Previous diagnoses and protocols
  - Antecedents and consequences

b. Family Background
  - Socioeconomic level
  - Cultural environment and background
  - Parent's occupations and current health
  - Emotional history
  - Medical history
  - Relationships between family members (single, married, separated, divorced, widowed, affective dynamic)

c. Developmental Personal History
  - Infancy
    - Birthing abnormalities
    - Parents' emotional state
  - Early and middle childhood
    - School
    - Peers
    - Interests
  - Adolescence
    - Dating
    - Acting out
    - Puberty
  - Early and middle adulthood
    - Career/occupational system
    - Relationships
    - Life goals
  - Late Adulthood
    - Reaction to changing abilities
    - Economics

d. During any phase
  - Traumas
  - Losses
  - Medical problems
  - Fears
  - Self-esteem
  - Economics
  - Relationships

ABILITY TESTING

1. Intelligence

There does not appear to be a consensus in the field about the definition of intelligence. Some of the offerings are:

- Global mental capacity
- Several separate factors
- General mental ability
- General intellectual factor
- Primary mental abilities
- Verbal-educational and spatial-motor factors
- Expression of an individual's ability level at a given time, in relation to the available age norms (Anastasi, 1988)
- Information measured by an intelligence test

A. Stanford-Binet Intelligence Scale

Developed in 1905 by Alfred Binet and Theodore Simon at the request of the French Minister of Public Education to identify retarded children, this test is probably the best known measure of intelligence in the public arena. The current test has been revised many times. The Fourth Edition was published in 1986 and has been changed both in structure and content. This edition is used for individuals aged 2 through adult.

Administration and Scoring

The test is given by an individual examiner to an individual examinee. The test portions given are chosen for appropriateness to their developmental level. The test provides the examiner with guidelines on how to determine this factor. Raw test scores are converted to Standard Age Scores according to the conversion tables in the test manual. A standard deviation of 8 is built into individual area scores (i.e., cognitive ability) and a standard deviation of 16 is built into the test composite.

B. Wechsler Tests - WAIS-R, WISC-R, WPPSI

First developed and published by David Wechsler in 1939 as a tool to assess intellectual ability of older adolescents and adults. Since then, other scales have been designed:

WAIS-R-(Wechsler Adult Intelligence Scale-Revised Edition)	ages 16 - 74
WISC-R-(Wechsler Intelligence Scale for Children-Revised Edition)	ages 6-16
WPPSI-(Wechsler Preschool and Primary Scale of Intelligence)	ages 4 - 6 1/2

The Wechsler tests reflect its authors view of intelligence as a global capacity with several interrelated functions. There are eleven subtests to the WAIS-R. All three tests indicate individual subtest scores as well as Verbal, Performance, and Full Scale deviation IQ scores.

Administration and Scoring

This test is administered much like the Stanford-Binet. The test alternates between verbal and performance subtests. Raw subtest scores are converted to standard scores with a mean of 10 and a standard deviation of 3. Subtest scores are summed and converted to deviation IQ's using conversion tables in the test manual.

C. Child, Infant and Preschool Tests

Developmental performance tests are usually used with this age population. Due to the short attention span and low test-taking tolerance these tests are difficult to administer and have lower levels of reliability than measures of intelligence in older children and adults. There is also the issue of the changing definition of intelligence at this age.

Some tests for this population are:

Bayley Scales of Infant Development
Brazelton Neonatal Assessment Scale
Cattell Infant Intelligence Scale
Gessell Developmental Schedule
Kaufman Assessment Battery
McCarthy Scales of Children's Abilities
Piagetian Scales

D. Tests for the Mentally Retarded

According to the American Association on Mental Deficiency (AAMD), mental retardation cannot be diagnosed on the basis of IQ test scores alone, they can only be diagnosed when low IQ is accompanied by deficits in the ability to cope with the demands of daily life. Since this area of assessment is particularly sensitive because of mandated treatment, educational laws and legislation, there are other criteria for testing this population.

Some tests often used are:

Adaptive Behavior Scale
Bruininks-Oseretsky Test of Motor Proficiency
Vineland Adaptive Behavior Scale

E. Tests for the Physically Handicapped

Tests often used to assess the general intellectual ability of hearing-impaired individuals, blind individuals, and individuals with orthopedic handicaps, are described below. There are also other tests that have been adapted for use with the handicapped, for example, the Stanford-Binet, Wechsler, SAT and Vineland are available for visually impaired examinees. Other tests include:

Arthur Point Scale or Performance Tests (Hearing loss)
Columbia Mental Maturity Scale (Orthopedic handicaps)
Haptic Intelligence Scale for the Blind (Blind)
Hiskey-Nebraska Test of Learning Ability (Hearing loss)
Peabody Picture Vocabulary Test - Revised (Orthopedic handicaps)
Porteus Maze Test

F. Cross-Cultural or Culture Fair Tests

As our culture becomes more ethnically diverse there is a growing need for tests that are "culture-fair." These tests are based on the assumption that cultures differ in language and in terms of the value they place on rapid performance, family, objects and information. Tests that meet these criteria are:

Black Intelligence Test of Cultural Homogeneity
Leiter International Performance Scale-Revised
Goodenough-Harris Drawing Test
IPAT Culture Fair Intelligence Test
Raven's Progressive Matrices
Test of Nonverbal Intelligence

G. Intelligence Tests for Industry

Industry long ago discovered they were ahead of the game if their employees had cognitive skills, job related knowledge, the ability to solve problems and interpersonal skills. Given this information, the employer can choose the best person for the required task or set of tasks.
Some measures that are used are:

Otis Self-Administered Test of Mental Ability
Personnel Tests for Industry
Wonderlic Personnel Test

H. Group Intelligence Tests

These tests are used in schools, industry and the armed services, or in any setting where large numbers of people are being examined. They are generally made up of multiple choice questions and administered in a large group setting. Their advantage is obvious, a large number of people are tested in less time. Their disadvantage includes the lack of ability to respond to the individual's needs, and the administrator not being able to observe test-taking behaviors. Group intelligence tests are considered to evaluate a more limited range of cognitive abilities than individual tests. One test most of us are familiar with is the SCAT (School and College Ability Tests) which is used to test academic achievement. Other tests include:

Cognitive Abilities Tests
Henmon-Nelson Tests of Mental Ability
Kuhlmann-Anderson Tests of Mental Ability
Multidimensional Aptitude Battery
Otis-Lennon School Ability Test

2. Computerized Adaptive Testing (CAT)

Computerized testing can adapt to the individual's responses and can stop testing when the individual's answers have provided enough information about their content mastery. They are used in educational, industrial and military settings.

PERSONALITY

Personality tests are used to "identify emotional, motivational, interpersonal and attitudinal characteristics," (Anastasi, 1988). It is believed these pull together and identify which "personality type" you are. The two major approaches to measuring personality are through a self-report inventory or a projective test. Some of the best known are:

1. Inventories

A. Minnesota Multiphasic Personality Inventory (MMPI)

The MMPI was created for use with people 16 years or older. It is made up of over 500 items (16 duplicated), that represent different scales of measurement. Questions include items such as: "I do not tire easily," "I am happy most of the time." The MMPI is a very widely used personality inventory. It reports against three validity scales (L, K, and F), and 10 clinical scales (Butcher & Williams, 1988).

1. Validity Scales

Validity scales are intended to measure the validity of the test scores. They consist of:

L - Lie scale, consists of 15 items that make an examinee appear in a favorable light. People who score high on this scale are presenting themselves in an excessively "pure" manner. High scores are represented by many false responses.

F - Measures consistency and is composed of 64 items that are rarely responded to in the scoreable direction. A high F score may result from extreme eccentricity, idiosyncrasy, psychiatric illness, response carelessness or scoring errors.

K - Suppresser variable, is made up of 30 items designed to assess the examinees need to present in a favorable light (high K) or attest to many personal defects or weaknesses (low K). K scores are used to compute a correction factor which is added to certain clinical scale scores to obtain adjustment scores.

2. Clinical Scales

Clinical scales measure specific clinical diagnosis. They include:

HS	Hypochondrias - concern with body symptoms
D	Depression - pessimism, hopelessness
HY	Hysteria - uses symptoms to solve problems
Pd	Psychopathic deviance - disregard for social standards
MF	Masculinity/Femininity - interests like those of the other sex
Pa	Paranoia
PT	Psychasthenia - worried, guilt feelings
Sc	Schizophrenia - withdrawn, bizarre thoughts
Ma	Hypomania - overactive, excited, impulsive
Si	Social Introversion - shy, inhibited

The MMPI can be very accurately computer scored

B. California Psychological Inventory (CPI)

The CPI can be used with ages 14 to adult. It's used in many environments including business, academic, military and counseling. It identifies potential leadership qualities, predicts achievement orientation, and selects and develops employees to ensure the best possible person for a job. The responses provide a profile on three major vectors:

◆ **First**	Client's interpersonal orientations, internality to externality
◆ **Second**	Normative orientation with peers
◆ **Third**	Sense of fulfillment.

C. Myers-Briggs Type Indicator (MBTI)

This instrument was developed in the 1920's by Katherine Briggs and her daughter Isabel Myers. It is a self-report instrument that identifies preferences for taking in information, making decisions and identifying a preference for an outer orientation toward action, people, or things, or an inner orientation toward ideas, concepts, and abstractions. The MBTI is used extensively in industry and by the military to match individuals to tasks and problem solving situations.

You will use the MBTI to help identify your best study method for this test.

D. Sixteen Personality Factor Questionnaire (16 PF)

In 1949 Raymond Cattell published the first edition of the 16 PF - the 16 Personality Factor Questionnaire. It was proposed to measure the whole of human personality using a structure discovered through factor analysis. This measure can be used in counseling settings as well as in career, business and industry. It helps in personnel selection and development. It identifies personal qualities that influence work-setting behaviors such as problem-solving style and interpersonal style. Scales included are: problem solving, stress, interpersonal relationships, work organization and environment, career interests and personal growth. Norms have been taken from high school, college and adult populations. This test can be computer scored with a variety of reports and narratives (Butcher, 1989).

E. Other Personality Assessments Include:

Edward's Personal Preference Schedule (EPPS)
Leary's Interpersonal Check List (ICL)
Millon Clinical Multiaxial Inventory (MCMI)
Schutz FIRO - B

2. Specialized

A. Bender Gestalt Test - Brain Dysfunction

A classic measure of visual-motor integration, the Bender Visual Motor Gestalt Test is designed to screen for brain dysfunction. The test consists of nine stimulus cards, each showing a figure. The client is asked to reproduce the figures, a task requiring visual association, motor coordination, and the ability to integrate the perceptual with the motor to achieve accurate reproduction of the stimulus.

B. Luria Nebraska Neurophsychological Battery

The Luria-Nebraska consists of 269 items selected on the basis of their importance in diagnosis. Each item represents an important aspect of the following 11 skill areas: motor functions, rhythm, tactile functions, visual functions, receptive speech, expressive speech, reading, writing, arithmetic, memory and intellectual processes. Raw scores for each item can be converted to scaled scores from 0 to 2, with a score of 0 suggesting that the examinee is functioning within the normal range and a score of 2 suggesting brain injury.

PROJECTIVE TESTS

Projective tests are based on the assumption that the individual reveals his/her personality through responses to the test stimuli. The projective test is relatively unstructured with few demands or tasks. The examiner is asked to interpret or structure his/her request as well as his/her responses. A major criticism of projective tests is that interpretation is based on the test provider's beliefs, perceptions and subsequent evaluations.

Projective instruments include a camouflaged testing procedure. The individual usually has no idea of what the examiner is looking for. The projective instrument is thought to assess the whole person including intellectual processes, conflicts, needs and emotional responsiveness, thus, completing a picture of the personality. It is believed that the projective techniques access latent or unconscious processes.

These tests are quantified. Scores or numbers are interpreted around some criterion or group norm. This gives the examiner a statistical idea of how the individual compares with others who had similar responses.

1. Classifications of projective test are:

Association Techniques - the individual is presented with a stimulus and responds with a word or precept, i.e., Rorschach and Word Association Tests

Construction Technique - a complex set of processes by which the individual develops a response to a given stimulus situation, i.e., Thematic Apperception Test

Completion Techniques - the person is asked to complete some stimulus or task, i.e., Sentence Completion

Choice Or Ordering Techniques - the person is asked to choose from a number of alternatives or stimuli's presented, i.e., Values Assessment

Expressive Techniques - a variety of procedures such as drawing, painting, and psychodrama that can simultaneously be methods of assessment and treatment, i.e., Draw A Person Test (Maloney, 1991)

2. Types of projective tests:

A. Rorschach

Henry Rorschach, a Swiss psychiatrist, published *Psychodiagnostics* in 1921, in which he presented a technique for assessing an individual's "whole" personality by the manner in which he responded to a number of inkblots. The test is composed of ten plates or cards on which bilaterally symmetrical inkblots have been printed. The subject is told they will be shown a number of inkblots and is asked to report what they may look like or what they remind them of. There are no right or wrong answers.

1. Administration

Administration is divided into three parts:

a. The initial inquiry phase during which the subject responds to the cards.

b. The second inquiry phase when the examiner goes through the subject's responses to each card asking general questions to determine how the subject arrived at their response.

c. A third phase, or testing the limits, is undertaken only when the subject shows no reaction to some of the blots. The examiner might prompt the subject by offering: "some people have seen this as a butterfly, can you show me how that might be?"

2. Scoring (Hertz, 1987)

The subject's responses are classified with five characteristics:

a. **Location**	Where on the card the concept was seen.
b. **Content**	Content of the response.
c. **Popular-Original**	The frequency with which the response occurs in a normative sense.
d. **Form Level**	How accurately the concept is seen.
e. **Determinant**	Shape, color, shading, movement.

3. Interpretation

Since the interpretation includes the total responses to all cards, interpretation is quite complex. Refer to Beck for more detailed interpretive techniques (Beck, 1944).

B. Thematic Apperception Test (TAT)

The TAT is another commonly used projective test (Bellak, 1988). It was introduced by Morgan and Murray in 1935 and published in 1943 by Henry Murray. The test is made up of twenty-nine pictures and one blank card. There are four different combinations of nineteen pictures which are selected for age and sex, along with a blank card. The TAT is thought to be a good tool for measuring hostility and achievement.

1. Administration

The subject is shown each picture and is informed they have five minutes to tell a story of what they see taking place on the card. They are encouraged to disregard the commonplace settings and let their imagination run free in myth, fairy tale, or allegory. Some examiners offer only ten cards at a time on two separate days and some choose the pictures for particular themes.

During the administration, the examiner's task is to record the stories verbatim. Tape recorders are a tremendous help in recording the information accurately. If the stories become too detailed, or go on too long, the examiner may interrupt and ask how the story ends or simply stop and go to the next picture. Examiners may also ask for the feelings or thoughts of the story characters if this data is not presented.

2. Scoring and Interpretation

Murray proposes a scheme of content analysis which is based on his "need system" approach to personality (Murray, 1943). He recommends analyzing the stories in terms of the force or forces emanating from the hero and the same emanating from the environment. The first step is to analyze the hero's characteristics, motives, strengths, weaknesses, feelings, and needs or drives. The combining of the their needs, and the environmental forces, and the outcome of the story produces what Murray calls a "thema." The themas for all the stories provide the major basis for interpretation.

The CAT, Children's Apperception Test is used for young populations.

C. House Tree Person

This test is exactly like it sounds. In the House-Tree-Person projective drawing test, the person is asked to draw a picture of themselves, a house, and a tree. The test is evaluated by analyzing the structure of the pictures. The test is for individuals age five and up and can be used with couples and families. Scoring guidelines are provided with the test. This test is thought to be a good test to reveal information about home life, family relationships, anxiety and current or historical childhood influences.

D. Incomplete Sentences Blank

Individuals fill in the information that is left blank in a sentence. It is interpreted by the examiner based on their experience and knowledge of the individual. There are several lists, one is the Forer Structured Sentence Completion Test.

BEHAVIORAL ASSESSMENTS

1. Gathering data

A lot of information can be gathered by watching an individuals "stream of behavior." Observations are formalized by creating tracking systems that describe, in a narrative or coding system, information such as:

A. Type of behavior described in an objective measurable manner.

B. Schedule of behavior - time of day or smaller measures (how many times a minute).

C. Antecedents to the behavior.

D. Consequences of the behavior.

E. Secondary gains of the behavior.

2. Measurement techniques include

A. Interviews

B. Physiological measures

C. Self-reports

D. Direct observations

3. Creating a behavioral change program

Behavioral assessments are usually made as a precursor to creating a behavioral change plan using behavior modification treatment techniques. As information is gathered, three steps take place:

A. **The target behavior to be modified is identified.**

B. **The best behavioral intervention/s are formulated.**

C. **The original behavioral measures are used to assess the effectiveness of the behavioral treatment interventions.**

This information is then used to create a behavioral change plan. The behavior can be intervened at any place in the behavior stream.

Specific tests for children:

Burk's Behavioral Rating Scales
Auchenbach's Child Behavior Checklist

FAMILY ASSESSMENTS

The main point to remember in assessment of families is that, in contrast to traditional assessment, the focus is not on the individual, but rather on the interactional patterns of the family system. Bodin (1968) has listed three broad approaches to family assessment.

1. Types of approaches

A. **Individual Approach -** Each family member is assessed and scores are compared to produce an indirect picture of family interaction. Some commonly used instruments are Leary's Interpersonal Check List (ICL) and Schutz's FIRO-B.

B. **Conjoint Approach -** consisting of both objective and subjective methods for assessing families.

C. **Combined Approach -** that uses both individual and conjoint data, such as Strodtbeck's "revealed differences" technique. Structured family interviews are widely used by clinicians to assess family interaction style, and to identify family strengths and weaknesses. Two such forms of assessment follow.

2. Specific tests

A. **The Wiltwyck Family Task (Elbert et al., 1964)**

This test is made up of eight tasks the whole family must complete. The first six tasks are presented through a tape recorder as the examiner watches the family through a one-way mirror. This non-participant observer model is useful because it removes any impact the examiner might make on the task solving process.

The eight tasks prescribed in the audio tapes are:

1. Agreeing on a meal everyone would enjoy.

2. Discussing: "Who's the most bossy," "the biggest troublemaker," "the one who gets away with the most," and "the biggest cry baby in the family."

3. Discussing a remembered argument at home, including how it started, how it developed, and what the outcome was.

4. Agreeing on a way to spend a $10 gift that would satisfy everybody.

5. Asking each member to tell what things every other member does that pleases them the most and makes them feel good, and what things each one does that displeases them most and makes them feel unhappy or mad.

6. Reassembling an asymmetric construction, each member starting with an equal number of pieces.

The remaining tasks are presented by the observer, who leaves the room after offering gifts about which the family must make decisions:

7. The family is offered its choice of a single gift, given a limited value, i.e., $1, $5.

8. The family is offered refreshments but provided with one cupcake, one coke and one cup less than the number of members present. The family is left to decide how to dispense the food, and as in the previous task, they must live with the decisions that are made.

B. The Structured Family Interview

This interview was developed by "The Palo Alto Group" at the Mental Research Institute (MRI) in California. This test is designed to give observers clinical impressions in a very short time, one hour. The interview is conducted by an interviewer and observed by another therapist. After completion of the interview, the therapist is introduced to the family. The family has already been guided to look at themselves as an interacting unit. The procedure was created with two primary goals in mind, first to gather a significant amount of information about a complex system quickly, and also as a therapeutic intervention early in treatment.

1. The five tasks in the interview utilize individual, dyadic and whole-family observations. The interviewer observes the discussion through a one-way screen.

   a. First, each member is asked individually, away from the family group, "What do you think are the main problems in your family?" Then, the group is assembled, and told that several discrepancies arose in the individual responses (whether they did or not), and asked to discuss the question together.

   b. Second, the family is asked to plan something more complex, such as an outing.

   c. Third, with the children excused, the parents are asked to describe how they met each other.

   d. Fourth, the parents are asked to discuss the meaning of a proverb and then bring the children into the room and teach them the meaning of the proverb.

   e. Fifth, the interviewer gives each person an index card and a pencil. Each member is asked to write down the main fault of the person on his left. The interviewer collects the cards and announces that he is adding two statements to the group responses. His statements are always "too good" and "too weak," but this fact is not revealed. After shuffling the cards, the interviewer reads each one to every member in turn, beginning with the father, and asks, "To whom do you think this applies?"

2. The major advantages of this type of approach are:

   a. It provides some common experience for researchers to use to make comparisons.

   b. The combination of common tasks or questions and open-ended (non restricted) responses have proved particularly popular.

C. Geneograms

Geneograms are family trees that include more detailed clinical and relational information. A wide range of information such as substance abuse, divorce, communication styles, and other information that helps identify the family and its dynamics are included.

VALUES ASSESSMENT

Values assessments range from the simple to the complex. They are based on the belief that individuals' behaviors are driven by their needs, which are then translated into personal values. Personal choices are made using the individual's personal values as the selection criteria.

APTITUDE TESTS

Aptitude tests are similar to intelligence tests but they are designed to measure a narrower range of capabilities. They are meant to measure the effects of general learning and to predict future performance. Some of the best known tests are:

1. Individual aptitude tests

A. General Clerical Tests

B. Musical Aptitude Profile

C. Purdue Pegboard

2. Multiaptitude test batteries

These are a number of tests or subtests that measure different aptitudes. These adapt themselves well to educational and vocational counseling in high school and college. They are also used by placement programs, state employment agencies, and the armed services.

A. Differential Aptitude Tests

1. Armed Services Vocational Aptitude Battery (ASVAB)
2. Career Ability Placement Survey (CAPS)
3. Flanagan Tests (FACT)
4. General Aptitude Test Battery (GATB)

B. Occupational Tests Of Special Aptitudes

These tests grew out of the work place trying to match employees to job descriptions. Tests include:

1. Clerical Aptitude Tests
2. Mechanical Aptitude Tests
3. Psychomotor Ability Tests

ACHIEVEMENT TESTS

Achievement testing is a measure of an individual's degree of mastery in a specific subject or task area. The tests can be designed by a teacher or standardized over an identified area. Different achievement tests are used for many purposes. They may test academic ability or professional ability, i.e., law exams, real estate licensing exams, etc.

Achievement tests may also be used diagnostically:

California Achievement Tests
Iowa Tests of Basic Skills
Stanford Achievement Test

1. Scholastic tests

Used in educational settings to predict future academic achievement.

Graduate Record Exam (GRE)
Miller Analogies Test
Scholastic Aptitude Test (SAT)

CAREER ASSESSMENT INSTRUMENTS

Interest and career measures compare the response of the tester with those of others at similar levels. One of the first career instruments was the Strong Vocational Interest Blank (SVIB). The revised edition, the Strong-Campbell Interest Inventory (SCII) is one of the most widely used and researched tests today.

1. Myers Briggs Type Indicator (MBTI)

The MBTI is a self-report instrument, meaning it measures your responses to the items. You, are the decision maker. The instrument is nonjudgmental. There is no right or wrong way to be, no correct or incorrect answers. When you take the MBTI, you choose some things and exclude others. The MBTI does not measure values or skills, but points out ways in which you can capitalize on your strengths.

People are different in fundamental ways yet there are similar drives that motivate us from within. The manner in which we pursue our needs and relate to others can be simplified, arranged into categories, and called preferences. By identifying what your preferences are, and those of people in your life, you can begin to appreciate differences rather than judge others as wrong or bad. The MBTI is elaborated on in a chapter in the test taking section.

2. Strong-Campbell

The Strong-Campbell is developed out of John Holland's theory of career development which notes six types of people and their environment:

Realistic	R
Investigative	I
Artistic	A
Social	S
Enterprising	E
Conventional	C

The test is a multiple choice test that is computer scored. Test results and many different types of narrative reports are available. The test compares individual interests with those of people successfully and happily employed in a large number of occupations.

3. Other tests commonly used in career counseling are:

Aptitude
Armed Services Vocational Aptitude Battery (ASVAB)
Career Ability Placement Tests (CAPS)
Differential Aptitude Tests (DAT)
General Aptitude Test Battery (GATB)

Interest
Career Assessment Inventory (CAI)
COPS Interest Inventory
Jackson Vocational Interest Survey
Kuder Vocational Preference Inventory
Ohio Vocational Preference Inventory
Self Directed Search (SDS)

Values
Career Orientation Placement and Evaluation Survey (COPES)
Minnesota Importance Questionnaire
Work Value Inventory

SELF-CONCEPTS, PERSONAL CONSTRUCTS AND SELF-REPORTS

Phenomenological psychology focuses on how individuals perceive events. Instruments can be used to assess how people view themselves and others. Self report inventories are often seen in popular magazines and are well received by clients. The clinician must be cautious in this arena since many tools have poor psychometric properties and no normative supporting information. On the other hand there are some instruments that have been used extensively and evaluated well. Some tests in this category include:

A. Personality Measures

- Millon Clinical Multiaxial Inventory (MCMI) - Adults 18 years plus with a minimum eighth-grade reading level. Assesses both Axis I and Axis II DSM disorders
- Edwards Personal Preference Schedule (EPPS)
- Personality Research Form (PRF)
- Washington University Sentence Completion Test - measures self conceptualization or ego development
- Self Esteem Measures
- Self-Esteem Scale (SES)
- Student Self-Concept Scale (SSCS)
- Personal and Academic Self-Concept Inventory (PASCI)
- Adjective Check List (ACL)
- Q-Sort
- Semantic Differential

B. Other Measures

- Role Construct Repertory Test - identifies client's constructs about others in their lives
- Perceived Environment and Social Climate
- Beck Depression Inventory (BDI)
- Fear Survey Schedule (FSS)
- Rathus Assertiveness Schedule (RAS)

COMMON TERMS

1. Standardized

A test can be called standardized for the "tester's" actions and language. The apparatus or equipment they use to test with have been fixed so that the test results collected are done at clearly identified times and in a particular manner. Any deviations from any of the above invalidates the test's outcome reports.

2. Performance measures

A well-defined task or situation is presented to the test taker and their performance is then measured. Maximum and minimum performance is assessed.

3. Self-report measures

Self-report is exactly as it sounds. The examinee reports to the clinician their beliefs, feelings, attitudes or any other information requested, to complete the assessment. Many personality tests are self-report.

4. Summative vs formative evaluation

Many achievement tests are used to evaluate instructional programs and/or materials. If an assessment, or assessment materials are provided during the learning process the outcomes can be used for formative evaluation. The goal being to optimize the materials or assessment process so the learner will learn more quickly or more in depth.

When a test is provided at the end of instruction, it is considered a summative evaluation of the effectiveness of the instruction in relationship to instructional goals.

Mental Status

CLIENT EVALUATION

1. The client evaluation consists of:
    - **A. Conducting a clinical interview - gathering data from a careful history of the client's problems**
    - **B. Conducting a mental status examination**
    - **C. Developing a differential diagnosis**
    - **D. Developing a treatment plan**
    - **E. A physical examination may also be needed**
2. Most clients are not psychotic, however even confused and disorganized clients can be helped to give accurate details of their history.
3. It is important to retain confidentiality in all therapist-client interactions, but particularly when psychological issues are discussed. Therapists should not discuss their clients in public places.
4. The rule of confidentiality may be broken when the need for safety becomes paramount, such as in cases of child abuse, elder abuse or when threats are made to harm oneself or others. This information should be told to clients as early as possible.

PSYCHOLOGICAL INTERVIEW

1. The client must feel comfortable enough to give information.
2. Non-verbal communication is as important as verbal communication. Also note how the client presents the material (i.e., the tone of voice, the feelings expressed).
3. During the first few minutes of the interview, the therapist should allow the client to talk about his or her major problem as the client sees it.

4. History of present illness. The interviewer should illicit information about:

- The onset or change over time of the symptoms.
- Stressful events, especially losses, including death, job loss, financial loss and any major changes in the client's life.
- The client's perception of any change in him or herself or report of any other individual's perception of change in the client.
- History of past psychiatric illness or treatment, including medications, hospitalizations, or other therapy.
- Any legal issues with regard to the present illness or, in the case of children, any problems in school.
- Any possible secondary gain - anything the client may see as being gained from the current problem, such as monetary compensation or relief from responsibilities at home, school, or work.

5. Personal history

A. Developmental Milestones

1. Early childhood development, including details about prenatal care, pregnancy and delivery.
2. Information regarding the client's temperament as a child as well as any important family events, such as death, separation, or divorce, that may have influenced the development of the temperament.
3. School (i.e., grades or delinquency), friends, family stability, early sexual experiences, neglect or abuse, the client's relationships as a child with his or her parents, siblings, and friends.

B. Social History

1. Gather information regarding the client's social life, such as is he or she a loner, how hard or easy is it for the client to make or keep friends.
2. Have any changes in personality been noted by the client or by his or her family or friends.
3. What is the marriage/partnership status and the current level of sexual functioning.
4. Determine the employment history, including the number of jobs the client has had, the reasons the jobs were terminated - note any problems with alcoholism or antisocial behavior.
5. Obtain a military service history including the highest rank attained and a history of any disciplinary problems or combat experience.

C. Family History

1. Information should be obtained about psychiatric illness, hospitalizations or any other kind of mental health treatment of a family member, including suicide attempts, problems with alcohol, or other psychiatric problems.

2. If possible, gather information regarding genetic risk factors as well as family attitudes toward mental illness and treatment.

3. Determine if any psychotropic medication is being used successfully by a family member for the same illness. There is a good chance that this medication will also be helpful to the present client.

D. Psychiatric History

Obtain information about any previous problem, including previous treatment, the name and address of the therapist, medications, and the outcome of treatment.

E. Use and Abuse of Substances

Always ask screening questions about alcohol and drug use, including whether or not family or friends ever objected to the client's drinking or drug problem or whether the client ever felt that he or she had a problem with alcohol or drugs (legal or illegal), including caffeine and tobacco. Obtain information about alcohol and drug use of other family members, presently and historically.

MENTAL STATUS EXAMINATION

The psychological history is a record of the client over the course of his or her entire life, whereas the mental status examination is an evaluation of the client at one point in time. During the interview, the clinician should make note of the following:

1. Appearance

A general description of overall appearance, dress, grooming, and any unusual features or gestures, particularly those that make the client unique or different should be noted.

2. Behavior and psychomotor activity

The clinician should note gait, position, and overall level of activity, noting any twitches, mannerisms, tics, agitation, or psychomotor retardation, clumsiness, rigidity, combatitiveness. Manic clients may be unable to sit still, whereas schizophrenic clients may exhibit bizarre postures or be abnormally stiff and awkward.

3. Attitude

It is important to note how the client relates to the clinician and to being interviewed, including whether the client is, e.g., cooperative, uncooperative, bored, seductive, hostile, frank, defensive, playful, evasive, guarded.

4. Speech

The clinician should describe how the client speaks: rapid, slow, pitch, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, ease, mumbled, relevance, manner, speech impairments (distinguish Aphasia which is due to neurological, not psychological illness).

5. State of consciousness

The client's alertness, responsiveness to environment, orientation, ability to carry out tasks (e.g. simple, then complex, ex: touching nose with finger, then touching another body part simultaneously) should be noted.

6. Mood and affect

"Mood" is the client's internal emotional state, while "affect" is the outward expression of the internal state. Determine if the mood and affect are congruent.

A. **How does client say he/she feels;** depth, intensity, duration and fluctuation of mood - depressing, despairing, irritable, panicky, terrified, angry, enraged.

B. **How does the interviewer evaluate the client's mood and affect:** manic, hypomanic, grandiose, agitated, flat, labile.

C. **Is the emotional expression appropriate** to the content, to the culture, to what the client is saying.

7. Anxiety level

A. **Client's Description:** are anxieties generalized and nonspecific or specifically related to particular situations, activities, or objects.

B. **How Are Anxieties Handled:** avoidance, repetition of feared situation, drugs or alcohol, other activities for distraction.

C. **Observations:** signs of anxiety - moist hands, perspiring forehead, restlessness, tense posture, strained voice, wide eyes, shifts in level of anxiety during interview, abrupt changes of topic.

8. Perception

Perceptual abnormalities involve the sensory nervous system and include:

A. Hallucinations

Hallucinations are false perceptions of a sensory stimulus in the absence of a sensory stimulus. Any sensory modality can be involved: auditory, visual, gustatory (taste) and olfactory (smell) tactile, and kinesthetic hallucinations. Hallucinations of any sort that occur while falling asleep (hypnagogic) or awakening (hypnopomic) are not necessarily considered serious or pathologic and are seen in normal individuals.

B. Illusions

An illusion is the misinterpretation of a true sensory stimulus. Illusions can be present in schizophrenia but are most common in delirium.

C. **Depersonalization and Derealization** are alterations in the perception of one's reality. With depersonalization, the client feels detached and views him or herself as strange and unreal. Derealization involves a similar alteration in the sense of reality of the outside world. Objects in the outside world may seem altered in size and shape, and people appear dead or mechanical.

9. Thinking process

The pattern of a client's speech allows the examiner to note the quality of the thought process, including its flow, logic, and associations. Abnormalities of the thinking process include:

A. **Abstract Reasoning** reflects the ability to understand concepts of similarities and differences, categories and classifications of items, behavior, etc., and perspective in relation to events.

B. **Loose Association** is the shifting of ideas from one to another with no logical connection. There is a lack of awareness on the part of the client that these ideas are not connected. The client's thoughts are difficult for the examiner to follow.

C. **Tangential Thinking** occurs when the client wanders off the subject as new but related words are spoken. The associations are not totally loose but the client often loses track of the question or point.

D. **Circumstantiality** occurs when the client loses the point of what he or she is trying to say but stays in the general topic area. Irrelevant details can be included if the client is merely anxious but can be severe if the client is delirious and distractible.

E. **Blocking** occurs when the thinking process stops altogether. The mind goes blank. Blocking can occur in states of acute anxiety as well as in schizophrenia.

F. **Perseveration** is the repetition of the same words or phrases over and over again.

G. **Echolalia** is the direct repetition of the interviewer's words, like a parrot.

H. **Flight of Ideas,** as seen in mania, involves rapid speech with quick changes of ideas that may be associated or may also involve loose associations.

10. Content of thought

Disturbances in the thought content include:

A. **Delusions,** which are fixed, false beliefs that are outside the client's culture. Delusions can be paranoid (or persecutory), grandiose, nihilistic, somatic, or bizarre. Delusions of reference involve the belief by the client that some person or object has special significance or power.

B. **Obsessions** are intrusive thoughts, ideas, or impulses that are persistent. The client recognizes that the ideas do not make sense and are not being imposed from outside (a delusion). Some commonly found obsessions are fears of contamination or obsessive unrealistic fears about physical health as seen in hypochondriasis.

11. Judgment

The social judgment of the client, i.e., whether the client understands the consequences of his or her actions should be assessed by the clinician. The clinician must, however, recognize differences in cultural values when assessing judgment.

12. Memory

The ability to recall and/or recognize the remote and recent past.

13. Intelligence

Assessment should be made of the general level of intellectual function of the client.

14. Concentration and attention span

The ability of the client to attend to and focus on tasks should be assessed.

15. Orientation

A formal mental status examination includes an assessment of a client's orientation to time (time, date, year), place (where client is) and person (who client is, and who clinician is).

THE CLINICAL REPORT

The clinical report includes:

1. **Preliminary identification:** name, age, marital status, sex, occupation, language if other than English; race, nationality, and religion (if pertinent), earlier episode of the same or a different condition.
2. **Chief complaint:** why did the person come to the office, preferably noted in the person's own words. If this information is given by someone else, state who supplied it.
3. **Personal identification -** brief description of appearance and behavior.
4. **History of present illness -** background and development of symptoms or behavioral changes that led person to seek assistance.
5. **Previous illnesses -** emotional or mental disturbances.
6. **Psychophysiological disorders -** ex: hay fever, rheumatoid arthritis, asthma, skin conditions.
7. **Past personal history**
   - ◆ Early childhood
   - ◆ Later childhood
   - ◆ Adulthood
8. **Family history**
9. **Marital history**
10. **Current social situation**

MENTAL STATUS ASSESSMENT WORKSHEET

Appearance

- Aloof
- Anxious
- Dejected
- Depressed
- Distractible
- Elated
- Hyperactive
- Hyper Alert
- Lethargic
- Neat
- Peculiar Dress
- Postural Problems
- Psychomotor Retardation
- Restless
- Slovenly
- Tense
- Vigilant
- Other

Attitude

- Cold
- Condescending
- Cooperative
- Demanding
- Deprecatory Of Self
- Disdainful
- Disinterested
- Egocentric
- Evasive
- Frank
- Hostile
- Over Idealizing Others
- Self-Deprecatory
- Sensitive
- Superior
- Suspicious
- Vain
- Other

Behavior

- Aggressive
- Angry
- Argumentative
- Arrogant
- Assertive
- Assaultive
- Belligerent
- Bizarre
- Cheerful
- Critical
- Dependent
- Dramatic
- Exploitative
- Exhibitionist
- Friendly
- Grossly Disorganized
- Guarded
- Helpless
- Hostile
- Indecisive
- Ingratiating
- Irritable
- Irascible
- Limited Empathy
- Manipulative
- Negativistic
- Passive
- Seeking Reassurance
- Subdued
- Obsequious
- Secretive
- Verbally Abusive
- Other

Behavioral Difficulties

- Arrests
- Breaking Rules
- Delinquency
- Impulse Control
  - Adequate
  - Impaired
- Initiation Of Fights
- Persistent Lying
- Repeated Drunkenness Or Substance Abuse
- Running Away From Home
- Sexual Promiscuity
- Thefts,
- Vandalism
- Other
- None Of The Above

Disturbances Of Motor Impairment

- Apraxia
- Aphoria
- Catatonia
- Echopraxia
- Fainting
- Fatigability
- Hyperactivity
- Jitteriness
- Loss Of Control Of:
  - Sphincters
  - Voluntary Muscles
- Muscle Aches
- Negativism
- Paralysis
- Posturing
- Retardation
- Shakiness
- Stupor
- Trembling
- Tremors
- Other
- None Of The Above

Somatic Changes Or Physical Complaints

Changes In Eating Patterns
Chest Pain Or Discomfort
Choking Or Smothering Sensations
Dyspnea
Dizziness, Fatigue
Faintness
Factitious Complaints
Hot And Cold Flashes
Hypersomnia
Insomnia
Menstrual Difficulties
Pain
Palpitations
Paresthesias
Sexual Drive Decreased
Sweating
Trembling Or Shaking
Vertigo Or Unsteady Feelings
Vomiting
Weight Gain
Weight Loss

Autonomic Hyperactivity

Circulatory System:
  Flushing
  Palpitations
  Pallor
  Pulse Rate Increase
Gastrointestinal System:
  Diarrhea
  Discomfort
  Dry Mouth
  Nausea
  Vomiting
Respiratory System:
  Hyperventilation
  Increased Rate
Miscellaneous:
  Cold Clammy Hands
  Dizziness
  Paresthesias
  Sweating
Other
None of the Above

Speech And Thought Progression

Range:
  Average
  Decreased
  Increased
  Mute
  Pressured
  Other
Progression:
  Blocking
  Circumstantial
  Changeable
  Concrete
  Condensed
  Concentration Loss
  Digressive
  Echolalic
  Flight Of Ideas
  Incoherent
  Indecisive
  Irrelevant
  Loosening Of Associations
  Neologistic
  Over Elaborate
  Perseverative
  Poverty Of Content
  Stereotypy
  Tangential
  Vague
  Verbigeration
  Word Salad
  Other
None of the Above

Affect

Aloof
Apathetic
Appropriate
Blunted
Cold
Flat
Inappropriate
Irritable
Labile
Temper
Outbursts
Other

Mood

Anxious
Elevated
Depressed
Within Normal Limits
Other
Supplemental Information Regarding Mood
Is Anxious Mood Associated With:
  Compulsions
  Obsessions
  Panic Attacks
  Phobias
Is Depressed Mood Associated With:
  Agitation
  Early-Morning Awakening
Decreased Effectiveness At:
  School
  Home
  Work
Decreased Enjoyment
Feeling Worse In The Morning
Feeling Inadequate
Feeling Slowed Down
Guilt
Loss Of Interest Or Enjoyment In Sex
Pessimism
Tearfulness
Is Elevated Mood Associated With:
  Decreased Need For Sleep
  Hyper Sexuality
  Distractibility
  Poor Judgment
Excessive Involvement With Pleasure
Increased:
  Creativity
  Energy
  Feelings Of Omnipotence
  Optimism
  Physical Activity
  Talkativeness
  Inappropriate Joking
  Laughing or Punning

Perceptions

Delusions Or Feelings Of:
- Being Controlled
- Blamelessness
- Body Image Disorder
- Disorganization
- Dying
- Entitlement
- Forgetfulness
- Going Crazy
- Grandiosity
- Guilt
- Helplessness
- Hypersensitivity
- Inability To Express Warmth
- Ideas Of Reference
- Inadequacy
- Indifference
- Indecisiveness
- Ineffectiveness
- Inflated Worth
- Insistence Upon Having Ones Own Way
- Jealousy
- Knowledge
- Limited Pleasure In Life
- Losing Control
- Magical Thinking
- Nihilism
- Objectivity
- Paranoia
- Persecution
- Poverty
- Power
- Religious Nature
- Self Reproach
- Special Identity
- Somatic
- Stubbornness
- Suspiciousness

Thought:
- Broadcasting
- Insertion
- Withdrawal
- Unreality
- Worthlessness

Other
None of the Above

Hallucinations

Auditory
Olfactory
Gustatory
Taste
Visual
Depersonalization:
Yes No
Fears Or Phobias:
Yes No
If Yes, Are They:
- Social
- Spatial
- Animal
- Other

Illusions: Yes No
Intellectualization:
Yes No
Obsessions, Compulsions, And Recurrent Thoughts
Yes No
Ego Dystonic
Ego Syntonic
Both
Over Determined Ideas, Preoccupation, And Trends:
Yes No
Level Of Consciousness:
- Clear
- Clouded
- Comatose

Memory Impairment:
Yes No
If Yes, Is There Impairment Of:
- Immediate Recall
- Recent Recall
- Past Recall
- Confabulation

Orientation

Person
Place
Time
Calculations:
- Normal
- Impaired

Aphasia
Agnosia
Difficulty In Naming Parts Of The Body
Level Of Information:
- Low
- Average
- High

Intelligence

Superior
Bright
Average
Dull Normal
Borderline
Retarded

Judgment And Insight

Judgment
- Adequate
- Impaired

Insight
- Adequate
- Impaired

Amnesiac Disturbances:
Yes No

Disturbance of Organs of Special Sense

- Auditory
  - Deafness
  - Hearing Loss
- Touch
  - Anesthesia
  - Numbness
- Visual
  - Blindness
  - Blurred Vision
  - Double Vision
- Other
- None of the Above

Assessment

Reliability of Information
Low/1 2 3 4 5/High
Immediate Treatment Interventions
Immediate Treatment Goals
Initial Prognosis
Referrals/Consultations
Working Diagnosis DSM-IV
Axis I
Axis II
Axis III
Axis IV
Axis V

CHAPTER 4

Diagnosis

DSM IV

1. History

The first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) was developed by the American Psychiatric Association in 1952. It used a psycho-biological approach and biological processes were believed to have caused most psychological problems. DSM-II was developed in 1968 and used until 1980. It established characteristics for psychosis and neurosis. DSM-III was used from 1980 until 1987. In this version the language was easier to understand and an attempt was made to be non-pejorative. This is the first version where both medical and non-medical persons worked together in the writing, giving credence to the idea that non-medical persons would also use the manual. This version of the DSM was more contemporary as the writers were more aware of societal changes. DSM-III-R (1987) was a further refining of DSM-III. The code numbers were tied into the ICD-9-CM, the International Classification of Diseases - Clinical Modification, ninth edition. The ICD is the manual used by the World Health Organization and was developed in Paris in 1900. It is revised approximately every 10 years. In 1994, the DSM-IV was released. This version emphasized the reciprocal relationship between biological problems and psychological disorders to a greater degree than any rendition since DSM-I. In a few places, the same code is used for more than one diagnosis. This happened because these diagnoses were together in the ICD and when separated for the DSM, the code remained the same in order to tie into the ICD. The DSM-IV will correlate with ICD-10 diagnostic codes when they are published. The DSM-IV is atheoretical, meaning that no one theory of diagnosing mental disorders is represented, thus all theories of intervention can be used in treatment.

The information in this chapter was developed with the help of the Introduction to DSM-IV, Linda Seligman, Ph.D., LPC, CCMHC, Workshop, Boston, MA, Oct., 1994.

BEST COPY AVAILABLE

2. Definition of a Mental Disorder

"In the DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above" (p. xxi - xxii, DSM-IV).

A. The Multiaxial System:

1.	Axis I	Clinical Syndromes and Other Conditions That May Be a Focus of Clinical Attention
2.	Axis II	Personality Disorders Mental Retardation
3.	Axis III	General Medical Conditions
4.	Axis IV	Psychosocial and Environmental Problems
5.	Axis V	Global Assessment of Functioning

B. The multiaxial classification system looks at the client through five lenses, seeing the whole person, and taking a holistic view. It is the basis for treatment planning. Axes I and II look at client symptoms and are the heart of the diagnosis.

1.	Axis I	Disorders are generally transient and are typically preceded by a period of emotional health. In most cases, the therapist hopes that the client will be totally free of the disorder at some later point.
2.	Axis II	Disorders are long-standing, deeply ingrained, potentially life-long and are ego-syntonic (a fundamental part of the person).

3. Axis I—Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention

If there is more than one diagnosis on Axis I, list them in order of treatment priority. The first diagnosis is the primary diagnosis and the focus of treatment.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation, which is diagnosed on Axis II)
Delirium, Dementia, and Amnestic and Other Cognitive Disorders
Mental Disorders Due to a General Medical Condition
Substance-Related Disorders
Schizophrenia and Other Psychotic Disorders
Mood Disorders
Anxiety Disorders
Somatoform Disorders
Factitious Disorders

Dissociative Disorders
Sexual and Gender Identity Disorders
Eating Disorders
Sleep Disorders
Impulse-Control Disorders Not Elsewhere Classified
Adjustment Disorders
Other Conditions That May Be a Focus of Clinical Attention (except borderline intellectual functioning)

4. Axis II—Personality Disorders and Mental Retardation

There can be more than one diagnosis on Axis II (may also include personality traits and defense mechanisms).

Paranoid Personality Disorder
Schizoid Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder Not Otherwise Specified
Mental Retardation

5. Axis III—General Medical Conditions

A condition listed on Axis III must be diagnosed by a physician and have an ICD-9-CM (or ICD-10-CM) code number. Current general medical conditions that are potentially relevant to the understanding or management of the person's mental disorder are reported. The medical condition is obtained by sending a signed Release of Information form to the physician requesting the results of the client's most recent physical examination. Some ICD-9-CM and ICD-10-CM numbers are listed in Appendix G of the DSM-IV. If the physician's specific diagnosis is not listed in Appendix G, contact the physician for the correct number. Medical conditions listed on Axis III are provisional until confirmation is received from a medical doctor, for example: "ulcers (provisional)". As soon as the information is obtained, Axis III should be changed to reflect the new information and "(provisional)" is deleted.

6. Axis IV—Psychosocial and Environmental Problems

Axis IV is a view of the client's world: what stressors are experienced in the client's outside world (not internal processes). Axis IV is for reporting psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders (Axes I and II). These may include life events, familial or other interpersonal stress, inadequacy of social support or personal resources. Axis IV may also include so-called "positive stressors" such as job promotion or the birth of a child, if they constitute or lead to a problem. Since there is no rating scale for Axis IV, merely list the stressors that the client has experienced in the previous year.

7. Axis V—Global Assessment of Functioning (GAF) Scale (1-100)

Axis V is for reporting the clinician's judgment of the client's overall level of functioning. This information is useful in treatment planning and measuring it's impact, as well as in predicting outcome. The GAF scale looks at the client's resources or coping. The rating is given on the client's current level of functioning, only.

90 - 100	Superior level of functioning - probably won't see these people in counseling.
80 - 90	Well-functioning people - they may have minor snags in their life, but usually won't have a mental disorder.
70 - 80	May have an Adjustment Disorder - they may be reactive people.
50 - 70	May see these people in outpatient settings - they may have anxiety and mood disorders - they are in touch with reality and are functioning, but can have severe problems.
50 and Below	These people have serious symptoms - they are in danger (therapist may think about inpatient recommendations) the lower the number, the more serious - they may have been in inpatient treatment sometime in their history - they may have to be maintained on medication.

8. Other Concepts Used in Diagnosis:

A. Code Numbers

DSM-IV gives three to five code numbers for each diagnosis. If there is an X in the 4th or 5th digit, replace the X with a number. It gives information regarding severity and other information.

B. Prior History

The client may have recovered from the disorder, but it is clinically important to note the history.

C. Degree of Severity

For each disorder, the seriousness of the client's symptoms should be indicated, particularly on Axis I. DSM-IV gives a set of criteria for each disorder. Designation of "Mild" meets the minimum number required, "Severe" meets all or almost all of the criteria and is significant impairment, "Moderate" is somewhere in between.

D. In Partial Remission

"In Partial Remission" is used when the full disorder had been met previously, but presently only some of the symptoms are in evidence or some of the symptoms have reappeared following a period of full remission.

E. In Full Remission

"In Full Remission" is used when the symptoms are no longer in evidence but it is still clinically relevant to note a history of the disorder or if the client has been on medication and is now off the medication and has been symptom-free for a long time.

F. “Rule Out” or “R/O”

“Rule out” or “R/O” is used when symptoms are similar for more than one disorder and more information is needed to determine the correct diagnosis.

G. “Provisional Diagnosis”

“Provisional Diagnosis” is used when there is a strong presumption that the full criteria will be met for a disorder, but more information is needed to make a firm diagnosis.

H. “Not Otherwise Specified” or “NOS”:

“Not Otherwise Specified” or “NOS” is noted at the end of most categories and is used when the symptoms do not meet the specific criteria of any disorder, but some symptoms fit into the category. It is not to be used as a “catch-all”.

I. Some of the code numbers are the same for more than one diagnostic category (because of the connection with ICD-9 or 10-CM), therefore it is important that the name of the diagnostic category be given as well as the number.

J. Example of how to record results of a DSM-IV evaluation:

Axis I	303.90	Alcohol Dependence
	296.33	Major Depressive Disorder, Recurrent, Severe without Psychotic Features
Axis II	301.6	Dependent Personality Disorder
		Frequent use of denial
Axis III	531.30	Ulcer, gastric, acute (code from ICD-9-CM)
Axis IV	531.70	Threat of job loss
Axis V	GAF	35 (current)

9. Cultural Formulation

A narrative paragraph may be added to address the relationship of socio-cultural factors to the diagnosis. The cultural formulation provides a systematic review of the individual’s cultural background and the role of the cultural context in the expression and evaluation of the person’s symptoms and dysfunctions. Also included are the effects that cultural differences may have on the relationship between the client and the clinician. The Cultural Formulation should be used if the clinician is working with a client from a different culture than her/his own. A narrative summary for each of the following categories may be included:

- Cultural identity of the individual
- Cultural explanations of the individual’s illness
- Cultural factors related to the psychosocial environment and levels of functioning
- Cultural elements of the relationship between the individual and the clinician
- Overall cultural assessment for diagnosis and care

THE DIAGNOSTIC CATEGORIES

Axis I - Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention. Explanations of the major categories are included here. It is recommended that each counselor have her/his own copy of the complete DSM-IV. For more detailed explanations refer to your

Note: Asterisks (*) denote changes from DSM-III-R.

Note: Numbers incorporate the 1996 updates from the American Psychiatric Press.

1. Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

(excluding Mental Retardation which is coded on Axis II).

A. Mental Retardation (code on Axis II)

Mental Retardation is defined as below average intellectual functioning, with onset before age 18, and concurrent deficits or impairments in adaptive functioning.

317	Mild Mental Retardation (IQ 50-55 to 70)
318.0	Moderate Mental Retardation (35-40 to 50-55)
* 318.1	Severe Mental Retardation (20-25 to 35-40)
318.2	Profound Mental Retardation (below 20-25)
319	Mental Retardation, Severity Unspecified

B. Learning Disorders (formerly Academic Skills Disorders)

Learning Disorders is defined as achievement on individually administered, standardized tests in reading, math, and written expression which is substantially below what would be expected for the age, schooling, and level of intelligence.

* 315.00	Reading Disorder
315.1	Mathematics Disorder
315.2	Disorder of Written Expression
315.9	Learning Disorder Not Otherwise Specified

C. Motor Skills Disorder

Motor Skills Disorders are marked impairments in the development of motor coordination.

* 315.4	Developmental Coordination Disorder

D. Communication Disorders

Communication Disorders are impairments in the areas listed below as demonstrated by scores on standardized, individually administered measures.

315.32	Mixed Receptive-Expressive Language Disorder
315.31	Expressive Language Disorder
315.39	Phonological Disorder (formerly Developmental Articulation Disorder)
307.0	Stuttering
307.9	Communication Disorder NOS

E. Pervasive Developmental Disorders

These disorders are defined as broad-based, severe and pervasive impairment or loss of functioning that would not be generally expected for the child's chronological age: social interaction skills, communication skills, or the presence of stereotyped behavior, interests or activities. These disorders are usually evident in the first 5 years of life and often associated with some degree of mental retardation (which, if present, is coded on Axis II).

299.00	Autistic Disorder
299.80	Rett's Disorder
299.10	Childhood Disintegrative Disorder
* 299.80	Asperger's Disorder
299.80	Pervasive Developmental Disorder NOS

F. Attention-Deficit and Disruptive Behavior Disorders

These disorders consist of a persistent pattern of disruptive, self-injurious, socially unacceptable, and/or environmentally destructive behaviors. Some symptoms must have been present before age 7. Diagnosis may be made into adulthood.

314.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
314.00	Attention-Deficit/Hyperactivity Disorder, Predominately Inattentive Type
314.01	Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9	Attention-Deficit/Hyperactivity Disorder NOS
312.xx	Conduct Disorder (specify whether Childhood-Onset Type, Adolescent-Onset type, Unspecified Onset)
313.81	Oppositional Defiant Disorder
* 312.9	Disruptive Behavior Disorder NOS

G. Feeding and Eating Disorders of Infancy or Early Childhood

Feeding and Eating Disorders consist of persistent disturbances of ingesting inappropriate substances, frequent regurgitating and rechewing food, or failure to gain or lose a significant amount of weight because of not eating adequately.

307.52	Pica
307.53	Rumination Disorder
307.59	Feeding Disorder of Infancy or Early Childhood

H. Tic Disorders

An irresistible, sudden, rapid, recurrent, stereotyped motor movement or vocalization.

307.23	Tourette's Disorder
307.22	Chronic Motor or Vocal Tic Disorder (more than 1 yr.)
307.21	Transient Tic Disorder (specify if single episode or recurrent)
307.20	Tic Disorder NOS

I. Elimination Disorders

Elimination of feces (Encopresis) or urine (Enuresis) at inappropriate times or places.

* 787.6	Encopresis With Constipation and Overflow Incontinence
* 307.7	Encopresis Without Constipation and Overflow Incontinence
307.6	Enuresis (Not Due to a General Medical Condition)

J. Other Disorders of Infancy, Childhood, or Adolescence

A diverse group of persistent disorders beginning in infancy, childhood, or adolescence including specific anxiety (separation), selective verbal expression (mutism), attachment (to care givers) and movement problems.

309.21	Separation Anxiety Disorder (specify if early onset or before age 6)
313.23	Selective Mutism (formerly Elective Mutism)
313.89	Reactive Attachment Disorder of Infancy or Early Childhood
307.3	Stereotypic Movement Disorder (formerly Stereotypy/Habit Disorder) (specify if with self-injurious behavior)
313.9	Disorder of Infancy, Childhood, or Adolescence NOS

2. *Delirium, Dementia, and Amnestic and other Cognitive Disorders

Multiple deficits in cognition or memory that represent a significant change from a previous level of functioning. The etiology is either the direct physiological effects of a general medical condition or the result of substance use or a combination of both.

A. Delirium

Delirium is a cognitive disorder characterized by impairment in consciousness, attention, and cognition such as: memory deficit, disorientation, language or perceptual disturbance.

293.0	Delirium Due to . . . (Indicate the General Medical Condition)
-.-	Substance Intoxication Delirium (code by substance)
-.-	Substance Withdrawal Delirium (code by substance)
-.-	Delirium Due to Multiple Etiologies (use multiple codes)
780.09	Delirium NOS

B. Dementia

Dementia is a cognitive disorder characterized by defects in memory, loss of ability to use or understand words (aphasia), inability to carry out motor activities despite intact comprehension and motor function (apraxia), failure to recognize or identify objects despite intact sensory function (agnosia), and executive functioning (cognitive abilities such as planning, organizing, sequencing, and abstracting).

290.xx.	Dementia of the Alzheimer's Type (specify if with or without behavioral disturbance) (also code 331.0 Alzheimer's Disease on Axis III)

With Early Onset: if onset at age 65 or before

290.10	Uncomplicated
290.11	With Delirium
290.12	With Delusions
290.13	With Depressed Mood

With Late Onset: if onset after age 65

290.0	Uncomplicated
290.3	With Delirium
290.20	With Delusions
290.21	With Depressed Mood
290.4x	Vascular Dementia (Multi-Infarct Dementia)
290.40	Uncomplicated

290.41	With Delirium
290.42	With Delusions
290.43	With Depressed Mood

Dementia Due to Other General Medical Conditions:

294.1	Dementia Due to HIV Disease
294.1	Dementia Due to Head Trauma
294.1	Dementia Due to Parkinson's Disease
294.1	Dementia Due to Huntington's Disease
290.10	Dementia Due to Pick's Disease
290.10	Dementia Due to Creutzfeldt-Jacob Disease
294.1	Dementia Due to . . . (Indicate the General Medical Condition not listed above)
-.-	Substance-Induced Persisting Dementia (code based on specific substance)
-.-	Dementia Due to Multiple Etiologies (use codes for specific etiologies)
294.8	Dementia NOS

C. Amnestic Disorders

Amnestic Disorders are cognitive disorders characterized by impairment of memory which is manifested in an inability to learn new information and to recall previously learned information.

294.0	Amnestic Disorder Due to . . . (Indicate the General Medical Condition) (specify if transient [lasts for 1 month or less] or chronic [lasts for more than 1 month])
-.-	Substance-Induced Persisting Amnestic Disorder (code based on specific substance)
294.8	Amnestic Disorder NOS

D. Other Cognitive Disorders

294.9	Cognitive Disorder NOS

3. *Mental Disorders due to a General Medical Condition not Elsewhere Classified (code medical condition on Axis III)

The presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition coded on Axis III.

293.89	Catatonic Disorder Due to . . . (Indicate the General Medical Condition)
310.1	Personality Change Due to . . . (Indicate the General Medical Condition) (specify type: labile, disinhibited, aggressive, apathetic, paranoid, other, combined, unspecified)
293.9	Mental Disorder NOS Due to . . . (Indicate the General Medical Condition)

4. *Substance-Related Disorders

Substance-Related Disorders are disorders related to the excessive or inappropriate taking of a drug, due to the side effects of a medication or to toxin exposure.

Relevant Terminology:

Dependence is a group of cognitive, behavioral and physiological symptoms that indicate the person is continuing to use the substance despite significant substance-related problems (minimum of 3 of 7 criteria within 1 year)

Abuse is a maladaptive pattern of substance use which is recurrent and has significant adverse consequences related to the repeated use of substances (min. of 1 of 4 criteria within 1 year).

Course Specifiers:

- With or without physiological dependence
- Remission (specify if early full, early partial, sustained full, sustained partial)
- On agonist therapy (Methodone, Antibuse - for alcohol)
- In a controlled environment (incarcerated, hospitalized, etc.)

A. Alcohol Related Disorders

1. Alcohol Use Disorders

303.90	Alcohol Dependence
305.00	Alcohol Abuse

2. *Alcohol-Induced Disorders (moved from Organic Mental Disorders)

303.00	Alcohol Intoxication
291.81	Alcohol Withdrawal
291.0	Alcohol Intoxication Delirium
291.0	Alcohol Withdrawal Delirium
291.2	Alcohol-Induced Persisting Dementia
291.1	Alcohol-Induced Persisting Amnestic Disorder

3. Alcohol-Induced Psychotic Disorder:

291.5	With Delusions
291.3	With Hallucinations
291.89	Alcohol-Induced Mood Disorder
291.89	Alcohol-Induced Anxiety Disorder
291.89	Alcohol-Induced Sexual Dysfunction
291.89	Alcohol-Induced Sleep Disorder
291.9	Alcohol-Related Disorder NOS

B. Amphetamine (or Amphetamine-Like)-Related Disorders

1. Amphetamine Use Disorders

304.40	Amphetamine Dependence
305.70	Amphetamine Abuse

2. *Amphetamine-Induced Disorders

292.89	Amphetamine Intoxication
292.0	Amphetamine Withdrawal
292.81	Amphetamine Intoxication Delirium

3. Amphetamine-Induced Psychotic Disorder:

292.11	With Delusions
292.12	With Hallucinations
292.84	Amphetamine-Induced Mood Disorder
292.89	Amphetamine-Induced Anxiety Disorder
292.89	Amphetamine-Induced Sexual Dysfunction
292.89	Amphetamine-Induced Sleep Disorder
292.9	Amphetamine-Related Disorder NOS

C. Caffeine Related Disorders

1. *Caffeine-Induced Disorders
    - 305.90 Caffeine Intoxication
    - 292.89 Caffeine-Induced Anxiety Disorder
    - 292.89 Caffeine-Induced Sleep Disorder
    - 292.9 Caffeine-Related Disorder NOS

D. Cannabis-Related Disorders

1. Cannabis Use Disorders
    - 304.30 Cannabis Dependence
    - 305.20 Cannabis Abuse

2. *Cannabis-Induced Disorders
    - 292.89 Cannabis Intoxication
    - 292.81 Cannabis Intoxication Delirium

3. Cannabis-Induced Psychotic Disorder:
    - 291.11 With Delusions
    - 292.12 With Hallucinations
    - 292.89 Cannabis-Induced Anxiety Disorder
    - 292.9 Cannabis-Related Disorder NOS

E. Cocaine-Related Disorders

1. Cocaine Use Disorders
    - 304.20 Cocaine Dependence
    - 305.60 Cocaine Abuse

2. *Cocaine-Induced Disorders
    - 292.89 Cocaine Intoxication
    - 292.0 Cocaine Withdrawal
    - 292.81 Cocaine Intoxication Delirium

3. Cocaine-Induced Psychotic Disorder:
    - 291.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Cocaine-Induced Mood Disorder
    - 292.89 Cocaine-Induced Anxiety Disorder
    - 292.89 Cocaine-Induced Sexual Dysfunction
    - 292.89 Cocaine-Induced Sleep Disorder
    - 292.9 Cocaine-Related Disorder NOS

F. Hallucinogen-Related Disorders

1. Hallucination Use Disorders
    - 304.50 Hallucinogen Dependence
    - 305.30 Hallucinogen Abuse

2. *Hallucinogen-Induced Disorders
    - 292.89 Hallucinogen Intoxication
    - 292.89 Hallucinogen Persisting Perception Disorder (Flashbacks)
    - 292.81 Hallucinogen Intoxication Delirium

3. Hallucinogen-Induced Psychotic Disorder:
    - 291.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Hallucinogen-Induced Mood Disorder
    - 292.89 Hallucinogen-Induced Anxiety Disorder
    - 292.9 Hallucinogen-Related Disorder NOS

G. Inhalant-Related Disorders

1. Inhalant Use Disorders
    - 304.60 Inhalant Dependence
    - 305.90 Inhalant Abuse

2. *Inhalant-Induced Disorders
    - 292.89 Inhalant Intoxication
    - 292.81 Inhalant Intoxication Delirium
    - 292.82 Inhalant-Induced Persisting Dementia

3. Inhalant-Induced Psychotic Disorder:
    - 291.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Inhalant-Induced Mood Disorder
    - 292.89 Inhalant-Induced Anxiety Disorder
    - 292.9 Inhalant-Related Disorder NOS

H. Nicotine-Related Disorders

1. Nicotine Use Disorder
    - 305.10 Nicotine Dependence

2. *Nicotine-Induced Disorder
    - 292.0 Nicotine Withdrawal
    - 292.9 Nicotine-Related Disorder NOS

I. Opioid-Related Disorders

1. Opioid Use Disorders
    - 304.00 Opioid Dependence
    - 305.50 Opioid Abuse

2. *Opioid-Induced Disorders
    - 292.89 Opioid Intoxication
    - 292.0 Opioid Withdrawal
    - 292.81 Opioid Intoxication Delirium

3. Opioid-Induced Psychotic Disorder:
    - 292.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Opioid-Induced Mood Disorder
    - 292.89 Opioid-Induced Sexual Dysfunction
    - 292.89 Opioid-Induced Sleep Disorder
    - 292.9 Opioid-Related Disorder NOS

J. Phencyclidine (PCP) (or Phencyclidine-Like)-Related Disorders

1. Phencyclidine Use Disorders
    - 304.60 Phencyclidine Dependence
    - 305.90 Phencyclidine Abuse

2. *Phencyclidine-Induced Disorders
    - 292.89 Phencyclidine Intoxication
    - 292.81 Phencyclidine Intoxication Delirium

3. Phencyclidine-Induced Psychotic Disorder:
    - 292.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Phencyclidine-Induced Mood Disorder
    - 292.89 Phencyclidine-Induced Anxiety Disorder
    - 292.9 Phencyclidine-Related Disorder NOS

K. Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

1. Sedative, Hypnotic, or Anxiolytic Use Disorders
    - 304.10 Sedative-, Hypnotic-, or Anxiolytic Dependence
    - 305.40 Sedative-, Hypnotic-, or Anxiolytic Abuse

2. *Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders
    - 292.89 Sedative-, Hypnotic-, or Anxiolytic Intoxication
    - 292.0 Sedative-, Hypnotic-, or Anxiolytic Withdrawal
    - 292.81 Sedative-, Hypnotic-, or Anxiolytic Intoxication Delirium
    - 292.81 Sedative-, Hypnotic-, or Anxiolytic Withdrawal Delirium
    - 292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
    - 292.83 Sedative-, Hypnotic-, Anxiolytic-Induced Persisting Amnestic Disorder

3. Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder
    - 292.11 With Delusions
    - 292.12 With Hallucinations
    - 292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
    - 292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
    - 292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction
    - 292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
    - 292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS

L. Polysubstance-Related Disorder

304.80	Polysubstance Dependence

M. Other (or Unknown) Substance-Related Disorders (e.g., anabolic steroids, nitrous oxide)

1. Other (or Unknown) Substance Use Disorders

304.90	Other (or Unknown) Substance Dependence
305.90	Other (or Unknown) Substance Abuse

2. *Other (or Unknown) Substance-Induced Disorders

292.89	Other (or Unknown) Substance Intoxication
292.0	Other (or Unknown) Substance Withdrawal
292.81	Other (or Unknown) Substance-Induced Delirium
292.82	Other (or Unknown) Substance-Induced Persisting Dementia
292.83	Other (or Unknown) Substance-Induced Persisting Amnestic Disorder

3. Other (or Unknown) Substance-Induced Psychotic Disorder:

292.11	With Delusions
292.12	With Hallucinations
292.84	Other (or Unknown) Substance-Induced Mood Disorder
292.89	Other (or Unknown) Substance-Induced Anxiety Disorder
292.89	Other (or Unknown) Substance-Induced Sexual Dysfunction
292.89	Other (or Unknown) Substance-Induced Sleep Disorder
292.9	Other (or Unknown) Substance-Related Disorder NOS

5. *Schizophrenia and Other Psychotic Disorders

Schizophrenia and Other Psychotic Disorders are a constellation of signs and symptoms associated with marked cognitive, social or occupational dysfunction, and marked impairment of reality testing.

A. Schizophrenia: (if duration 1 year +, specify course)

Symptoms of Schizophrenia include: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior - continuous symptoms for at least 6 months.

295.10	Disorganized Type
295.20	Catatonic Type
295.30	Paranoid Type
295.60	Residual Type
295.90	Undifferentiated Type

B. 295.40 Schizophreniform Disorder (specify if with or without good prognostic features)*

Symptoms of Schizophreniform Disorder are the same as for Schizophrenia, but the duration is 1-6 months - impaired social or occupational functioning are not necessarily present.

C. 295.70 Schizoaffective Disorder (specify if bipolar or depressive type)*

Schizoaffective Disorder is defined as an uninterrupted period of illness in which there is a Major Depressive, Manic, or Mixed Episode concurrent with symptoms of Schizophrenia.

D. 297.1 Delusional Disorder (specify type: erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified)

Delusional Disorder is the presence of 1 or more non-bizarre delusions persisting for at least 1 month.

E. *298.8 Brief Psychotic Disorder (specify with or without marked stressors or with postpartum onset)

Brief Psychotic Disorder is the sudden onset of psychotic symptoms of delusions, hallucinations, disorganized speech or grossly disorganized or catatonic behavior of at least 1 day, but less than 1 month.

F. 297.3 Shared Psychotic Disorder (Folie a Deux)

Shared Psychotic Disorder is defined as a delusion that develops in a person who is in a close relationship with another person who has a psychotic disorder with delusions.

G. *Psychotic Disorder Due to . . . (Indicate the General Medical Condition)

This disorder is defined as a psychotic disorder resulting from a medical condition.

293.81	With Delusions
293.82	With Hallucinations

H. *-.- Substance-Induced Psychotic Disorder (code based on specific substance)

This disorder is defined as a psychotic disorder resulting from the use of a substance.

I. 298.9 Psychotic Disorder NOS

6. Mood Disorders

Major symptom is a depressed mood, including feeling sad, hopeless, discouraged, "down in the dumps".

Specifiers:

- melancholic features
- atypical features
- catatonic features
- rapid cycling
- seasonal pattern
- postpartum onset
- with or without inter-episode recovery

A. Depressive Disorders

296.xx Depressive Disorders are defined as 1 or more major depressive episodes with depressed mood and other depressive symptoms for at least 2 weeks.

1. Major Depressive Disorder: The essential feature is a period of at least 2 weeks with either depressed mood or loss of interest or pleasure in nearly all activities. In children or adolescents, the mood may be irritable rather than sad. At least 4 other symptoms must be present: changes in appetite or weight, sleep, psychomotor activity; decreased energy, feelings of worthlessness or

guilt; difficulty thinking, concentrating or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. Symptoms must be new or clearly worse than before the episode. Symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must include clinically significant distress or impairment in social, occupational, or other important areas of functioning or needing markedly increased effort in functioning. Specify severity - Replace x with current state of disorder: 0 unspecified, 1 mild, 2 moderate, 3 severe without psychotic features, 4 severe with psychotic features, 5 in partial remission, 6 in full remission.
296.2x Single Episode

2. 296.3x Recurrent
311 Depressive Disorder NOS

3. 300.4 Dysthymic Disorder (specify if early or late onset, with atypical features)
Dysthymic Disorder is defined as 2 years of depressed mood on more days than not which do not meet the criteria for Major Depressive Episode. Dysthymic Disorder is chronic, with less severe depressive symptoms that have been present for many years. It can be diagnosed following Major Depressive Disorder only if it was established prior to the first Major Depressive Disorder or there has been a full remission of the Major Depressive Disorder.

B. Bipolar Disorders

1. *296 Bipolar I Disorder: (specify severity, other features) - 1 or more Manic or Mixed Episodes usually with a Major Depressive Episode.

A Manic Episode is a period of time (usually at least 1 week) of abnormally and persistently elevated, expansive, or irritable mood with symptoms such as inflated self-esteem or grandiosity, decreased need for sleep, over-talkativenss or pressured speech, flight of ideas, racing thoughts, inattentiveness and distractibility.

A Hypomanic Episode is similar to a Manic Episode except it is not as severe and would not cause marked impairment in social or occupational functioning or hospitalization.
296.0x Single Manic Episode
296.40 Most Recent Episode Hypomanic
296.4x Most Recent Episode Manic
296.5x Most Recent Episode Depressed
296.6x Most Recent Episode Mixed
296.7 Most Recent Episode Unspecified

2. 296.89 Bipolar II Disorder (Recurrent major depressive episodes with at least 1 Hypomanic Episode) (Specify current or most recent episode, severity, other features)
3. 301.13 Cyclothymic Disorder - at least 2 years of many periods of hypomanic symptoms and depressive symptoms
4. 296.80 Bipolar Disorder NOS

C. Other Mood Disorders

1. * 293.83 Mood Disorder Due to . . . (Indicate the General Medical Condition) (specify type of mood disorder)
2. * -.- Substance-Induced Mood Disorder (code based on specific substance)
3. 296.90 Mood Disorder NOS

7. Anxiety Disorders

Disorders precipitated by intense fear and distress, characterized by feelings of anxiety. Panic Attacks (not codable alone) consist of a period of intense fear or discomfort with 4 or more physical symptoms or intense fears.

Agoraphobia is defined as anxiety about being in places or situations in which escape might be difficult or embarrassing or in which help may not be available should a panic attack occur. It is usually typified by a fear of going into the open, of leaving one's home or of being in a crowd, standing in line, or traveling in a car or train.

A.	300.01	Panic Disorder Without Agoraphobia
B.	300.21	Panic Disorder With Agoraphobia
C.	300.22	Agoraphobia Without History of Panic Disorder
D.	*300.29	Specific Phobia (formerly Simple Phobia) (specify type: animal, natural environment, blood/injection/injury, situational, other)*
E.	*300.23	Social Phobia (formerly Social Anxiety Disorder) (specify if generalized type)* (subsumes Avoidant Disorder of Childhood)*
F.	300.3	Obsessive-Compulsive Disorder (specify if with poor insight)*
G.	*309.81	Posttraumatic Stress Disorder (specify if acute or chronic, and with delayed onset)
H.	*308.3	Acute Stress Disorder (new)
I.	300.02	Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)*
J.	293.84	Anxiety Disorder Due to . . . (Indicate the General Medical Condition) (specify if with generalized anxiety, panic attacks, or obsessive-compulsive symptoms)
K.	*-.-	Substance-Induced Anxiety Disorder (code based on specific substance)
L.	300.00	Anxiety Disorder NOS

8. Somatoform Disorders

Somatoform Disorders are the presence of actual or perceived physical symptoms not fully explained by a general medical condition, by direct effects of a substance, or another mental disorder

A.	*300.81	Somatization Disorder
B.	*300.82	Undifferentiated Somatoform Disorder
C.	300.11	Conversion Disorder (specify type of symptom or deficit: motor, sensory, seizures or convulsions, mixed)
D.	*307.80	Pain Disorder Associated with Psychological Factors (formerly Somatoform Pain Disorder) (specify if acute or chronic)
E.	*307.89	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition
F.	300.7	Hypochondriasis (specify if with poor insight)*
G.	300.7	Body Dysmorphic Disorder
H.	300.82	Somatoform Disorder NOS

9. Factitious Disorders

Factitious Disorders are physical or psychological symptoms intentionally produced or feigned so as to put oneself in the role of being sick or taken care of.

A. *300.16 Factitious Disorder With Predominantly Psychological Signs and Symptoms
B. *300.19 Factitious Disorder With Predominantly Physical Signs and Symptoms
C. *300.19 Factitious Disorder With Combined Psychological and Physical Signs and Symptoms
D. 300.19 Factitious Disorder NOS

10. Dissociative Disorders

Dissociative Disorders are defined as the sudden, gradual, transient or chronic disruption of the integrated functions of consciousness, memory, identity, or perception of the environment.

A. *300.12 Dissociative Amnesia (formerly Psychogenic Amnesia)
B. *300.13 Dissociative Fugue (formerly Psychogenic Fugue)
C. *300.14 Dissociative Identity Disorder (formerly Multiple Personality Disorder)
D. 300.6 Depersonalization Disorder
E. 300.15 Dissociative Disorder NOS

11. Sexual and Gender Identity Disorders

Sexual and Gender Identity Disorders are disturbances in sexual desire and the psychophysiological changes characterizing the sexual response cycles and which cause distress and interpersonal difficulty.

A. **Sexual Dysfunctions** (specify due to psychological factors or due to combined psychological factors and a general medical condition: lifelong or acquired: generalized or situational)*

1. Sexual Desire Disorders
    a. 302.71 Hypoactive Sexual Desire Disorders
    b. 302.79 Sexual Aversion Disorder

2. Sexual Arousal Disorders
    a. 302.72 Female Sexual Arousal Disorder
    b. 302.72 Male Erectile Disorder

3. Orgasmic Disorders
    a. *302.73 Female Orgasmic Disorder (formerly Inhibited Female Orgasm)
    b. *302.74 Male Orgasmic Disorder (formerly Inhibited Male Orgasm)
    c. 302.75 Premature Ejaculation

4. Sexual Pain Disorders (not due to a general medical condition)
    a. 302.76 Dyspareunia
    b. 306.51 Vaginismus

5. *Sexual Dysfunctions Due to . . . (Indicate the General Medical Condition)
    a. 625.8 Female Hypoactive Sexual Desire Disorder Due to . . . (Indicate the General Medical Condition)
    b. 608.89 Male Hypoactive Sexual Desire Disorder Due to . . . (Indicate the General Medical Condition)
    c. 607.84 Male Erectile Disorder Due to . . . (Indicate the General Medical Condition)
    d. 625.0 Female Dyspareunia Due to . . . (Indicate the General Medical Condition)
    e. 608.89 Male Dyspareunia Due to . . . (Indicate the General Medical Condition)

f. 625.8 Other Female Sexual Dysfunction Due to . . . (Indicate the General Medical Condition)
g. 608.89 Other Male Sexual Dysfunction Due to . . . (Indicate the General Medical Condition)

6. *-.- Substance-Induced Sexual Dysfunction (code based on specific substance)

7. 302.70 Sexual Dysfunction NOS

B. Paraphilias

Paraphilias are recurrent, intense sexual urges and sexually arousing fantasies that involve nonhuman objects, children or other non-consenting persons, or the suffering or humiliation of oneself or the sexual partner.

1. 302.4 Exhibitionism
2. 302.81 Fetishism
3. 302.89 Frotteurism
4. 302.2 Pedophilia (specify if sexually attracted to males, females, or both; if limited to incest; exclusive or nonexclusive type)
5. 302.83 Sexual Masochism
6. 302.84 Sexual Sadism
7. 302.3 Transvestic Fetishism (specify if with gender dysphoria)*
8. 302.4 Exhibitionism
9. 302.82 Voyeurism
10. 302.9 Paraphilia NOS

C. *Gender Identity Disorders (for sexually mature individuals, specify if sexually attracted to males, females, both, or neither)

Gender Identity Disorders are disorders characterized by a strong and persistent identification with the opposite sex and discomfort with one's assigned sex or a sense of inappropriateness in that gender role.

1. 302.6 Gender Identity Disorder in Children
2. *302.85 Gender Identity Disorder in Adolescents and Adults
3. 302.6 Gender Identity Disorder NOS

D. 302.9 Sexual Disorder NOS

12. *Eating Disorders

Severe disturbances in eating behavior.

A. 307.1 **Anorexia Nervosa** (specify if restricting type or binge eating purging type)*

Anorexia Nervosa is characterized by refusal or inability to maintain minimum normal weight (e.g., 85% of normal body weight) for one's age and height along with intense fears of gaining weight or becoming fat even though underweight. In females, failure to menstruate for at least 3 consecutive cycles (amenorrhea). In the restricting type, the person does not regularly engage in binge eating. In the binge eating/purging (bulimic) type, the person engages in recurrent episodes of binge eating or purging during the episodes of anorexia nervosa.

B. 307.51 **Bulimia Nervosa** (specify if purging or non-purging type)*

Bulimia Nervosa is characterized by recurrent episodes of binge eating followed by compensatory behavior such as purging or other methods to control weight, such as strict dieting, fasting, or vigorous exercise. These persons are able to maintain body weight at or above a minimally normal level.

C. 307.50 Eating Disorder NOS

13. Sleep Disorders

Severe disturbances in sleeping (organized by presumed etiology).

A. *Primary Sleep Disorders (new category)

1. Dyssomnias
    - a. 307.42 Primary Insomnia
    - b. 307.44 Primary Hypersomnia
    - c. *347 Narcolepsy
    - d. *780.59 Breathing-Related Sleep Disorder (code medical condition on Axis III)
    - e. 307.45 Circadian Rhythm Sleep Disorder (specify if delayed sleep phase type, jet lag type, shift work type, or unspecified)*
    - f. 307.47 Dyssomnia NOS
2. Parasomnias
    - a. 307.47 Nightmare Disorder
    - b. 307.46 Sleep Terror Disorder
    - c. 307.46 Sleepwalking Disorder
    - d. 307.47 Parasomnia NOS

B. *Sleep Disorders Related to Another Mental Disorder (new category)

1. 307.42 Insomnia Related to . . . (Indicate the Axis I or Axis II disorder)
2. 307.44 Hypersomnia Related to . . . (Indicate the Axis I or Axis II disorder)

C. Other Sleep Disorders *Sleep Disorder Due to . . (Indicate the General Medical Condition):

780.52 Insomnia Type
780.54 Hypersomnia Type
780.59 Parasomnia Type
780.59 Mixed Type
-.- Substance-Induced Sleep Disorder (specify type) (code based on specific substance)

14. Impulse-Control Disorders Not Elsewhere Classified

Failure to resist an impulse, drive or temptation or perform an act that is harmful to the person or others. The cycle pattern is: generally the person feels an increasing sense of tension or arousal before committing an act, then experiencing pleasure, gratification, or relief when committing the act. Subsequent to the act there may or may not be regret, self-reproach, or guilt. A period of calm ensues, then increased tension or arousal begins again and the cycle is repeated.

A. 312.34 **Intermittent Explosive Disorder**

This disorder consists of aggressive outbursts (assultiveness or destruction of property) that are out of proportion to any evident stressors.

B. 312.32 **Kleptomania**

This Impulse-Control Disorder consists of episodes of stealing objects that are not needed for personal use or for their monetary value.

C. 312.33 **Pyromania**

Pyromania is deliberate and purposeful firesetting on more than one occasion.

D. 312.31 **Pathological Gambling**

Pathological Gambling is characterized by the preoccupation with gambling, planning the next gambling time, scheming or illegal activity to get money to gamble with, gambling with more and more money to get the desired excitement, difficulty or failure to stop gambling, concealing the extent of the involvement in gambling, negative effects on relationships or career because of the focus on gambling.

E. 312.39 **Trichotillomania**

This disorder is pathological hair pulling resulting in noticeable hair loss.

F. 312.30 **Impulse Control Disorder NOS**

15. *Adjustment Disorders (specify if acute or chronic)*

Development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor (s) and must develop within 3 months of the onset of the stressor (s). The symptom must be resolved within 6 months of termination of the stressor(s) or its consequences. If symptoms occur in response to a chronic stressor or a stressor with enduring consequences, the symptoms may last longer than 6 months.

A. ***Adjustment Disorder:**

309.0	With Depressed Mood
309.24	With Anxiety
309.28	With Mixed Anxiety and Depressed Mood
309.3	With Disturbance of Conduct
309.4	With Mixed Disturbance of Emotions and Conduct
309.9	Unspecified

Axis II

16. Personality Disorders

Long-standing, deeply ingrained, ego-syntonic, maladaptive behaviors, responses and modes of thought. The disorders usually begin by early adulthood, often interfering with normal interpersonal relationships and creating functional impairment and/or subjective distress.

Cluster A: Odd, suspicious, eccentric group

A. 301.0 **Paranoid Personality Disorder**

This personality disorder is characterized by distrust and suspiciousness. Other people's motives are seen as having evil intent.

B. 301.20 **Schizoid Personality Disorder**

This disorder is characterized by detachment from social relationships and restricted emotional expression

C. 301.22 **Schizotypal Personality Disorder**

This is a personality disorder characterized by great discomfort in close relationships, cognitive or perceptual distortions, and eccentric behavior.

Cluster B: Dramatic, emotional, erratic, egocentric group

A. 301.7 **Antisocial Personality Disorder**

This is a personality disorder characterized by disregard for and violation of the rights of others. The person must be at least 18 years of age and may have been diagnosed with Conduct Disorder prior to age 15.

B. 301.83 **Borderline Personality Disorder**

In this personality disorder, the person evidences instability in interpersonal relationships, self-image, affect and impulsivity.

C. 301.50 **Histrionic Personality Disorder**

This is a personality disorder where a person evidences excessive emotionality and attention seeking behaviors.

D. 301.81 **Narcissistic Personality Disorder**

This personality disorder is characterized by grandiosity, need for admiration, and lack of empathy toward others.

Cluster C: Anxious, fearful, indirect group

A. 301.82 **Avoidant Personality Disorder**

Avoidant Personality Disorder is characterized by social inhabition, feelings of inadequacy, and hypersensitivity to negative evaluation or the perception of negative evaluation.

B. 301.6 **Dependent Personality Disorder**

In this personality disorder, the person evidences submissive and clinging behavior and excessive need to be taken care of.

C. 301.4 **Obsessive-Compulsive Personality Disorder**

This personality disorder is characterized by the preoccupation with orderliness, perfection and control resulting in less flexibility, openness and efficiency.

D. 301.9 **Personality Disorder NOS**

AXIS I - NOT MENTAL DISORDERS

17. Other Conditions That May Be a Focus of Clinical Attention

A. 316 ***Psychological Factors Affecting Medical Condition**

These problems may be the focus of therapeutic attention, but do not meet the criteria of a mental disorder.

Choose a name based on nature of factors:

Mental Disorder Affecting . . . (Indicate the General Medical Condition)
Personality Traits (or Coping Style) Affecting . . . (Indicate the General Medical Condition)
Maladaptive Health Behaviors Affecting . . . (Indicate the General Medical Condition)
Stress-Related Physiological Response Affecting . . . (Indicate the General Medical Condition)
Other or Unspecified Factors Affecting . . . (Indicate the General Medical Condition)

B. *Medication-Induced Movement Disorders:

1.	*332.1	Neuroleptic-Induced Parkinsonism
2.	*333.92	Neuroleptic Malignant Syndrome
3.	*333.7	Neuroleptic-Induced Acute Dystonia
4.	*333.99	Neuroleptic-Induced Acute Akathisia
5.	*333.82	Neuroleptic-Induced Tardive Dyskinesia
6.	*333.1	Medication-Induced Postural Tremor
7.	*333.90	Medication-Induced Movement Disorder NOS
8.	*995.2	Adverse Effects of Medication NOS

C. Relational Problems:

*V61.9	Relational Problem Related to a Mental Disorder or General Medical Condition
V61.20	Parent-Child Relational Problem
V61.10	Partner Relational Problem
V61.8	Sibling Relational Problem
V62.81	Relational Problem NOS

D. *Problems Related to Abuse or Neglect (new category):

*V61.21	Physical Abuse of Child (995.54 if attention is on victim)
*V61.21	Sexual Abuse of Child (995.53/victim)
*V61.21	Neglect of Child (995.52/victim)
Physical Abuse of Adult	
V61.12	(if by partner)
V62.83	(if by person other than partner)
Sexual Abuse of Adult	
V61.12	(if by partner)
V62.83	(if by person other than partner)

E. Additional Conditions That May Be a Focus of Clinical Attention:

V15.81	Noncompliance with Treatment
V65.2	Malingering
V71.01	Adult Antisocial Behavior
V71.02	Childhood or Adolescent Antisocial Behavior
V62.89	Borderline Intellectual Functioning (IQ 70-80) (Axis II)
*780.9	Age-Related Cognitive Decline
V62.82	Bereavement
V62.3	Academic Problem
V62.2	Occupational Problem
*313.82	Identity Problem
*V62.89	Religious or Spiritual Problem
*V62.4	Acculturation Problem
V62.89	Phase of Life Problem

F. Additional Codes:

300.9	Unspecified Mental Disorder (nonpsychotic)
V71.09	No Diagnosis or Condition on Axis I
799.9	Diagnosis or Condition Deferred on Axis I
V71.09	No Diagnosis on Axis II
799.9	Diagnosis or Condition Deferred on Axis II

SUMMARY OF KEY CHANGES FROM DSM-III-R

1. Content changes in DSM-IV manual

A. In DSM-IV there is a greater emphasis on biological processes, medical conditions and substance use.
B. Additional qualifiers and specifiers are added to identify diagnoses more specifically.
C. Some qualifiers are changed for clarity.
D. Child disorders now include only those diagnoses that begin in early childhood.
E. Disorders included in the DSM-III-R Organic Mental Disorders section, now are in a Cognitive Disorders group of Delirium, Dementia and Amnestic and Other Cognitive Disorders.
F. DSM-IV includes a recognition of cultural differences and the need to be aware of them.
G. DSM-IV is compatible with ICD-10 codes.
H. DSM-IV includes new or amended appendices including the following:

Appendix B	Criteria Sets and Axes Provided for Further Study
Appendix D	Annotated Listing of Changes in DSM-IV
Appendix G	ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders
Appendix H	DSM-IV Classification With ICD-10 Codes
Appendix I	Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes

2. Changes in the multiaxial system

A. Axis I

- Clinical Syndromes
- Other Conditions That May be a Focus of Clinical Attention (now includes Developmental Disorders that were coded on Axis II in DSM-III-R)

B. Axis II

- Personality Disorders
- Mental Retardation (may also include personality traits, defense levels and defense mechanisms - listed on DSM-IV pages 751-753)

C. Axis III

- Physical problems listed must be verified by a physician.
- Use ICD-9-CM codes in Appendix G, or obtain code from a physician.

D. Axis IV

- List Psychosocial and Environmental Problems - no code number is included. A code number was needed in DSM-III-R.

E. Axis V

- Expanded Global Assessment of Functioning (GAF) Scale from 1 - 100. Proposed Axes for Further Study may be used in addition to the GAF scale.
- Global Assessment of Relational Functioning (GARF) Scale

- Social and Occupational Functioning Assessment Scale (SOFAS). Cultural Formulation may also be used.

3. Changes in diagnostic categories

A. Disorders that were deleted from DSM-III-R or are now subsumed under other DSM-IV categories

1. Child Disorders

Cluttering - deleted; now code under Communication Disorders
Overanxious Disorder of Childhood - deleted; now code under Generalized Anxiety Disorder
Avoidant Disorder of Childhood - now code under Social Phobia
Undifferentiated Attention-Deficit Disorder - deleted; now code under Attention-Deficit/Hyperactivity Disorder
Identity Disorder - now under Identity Problem - V code
  Gender Identity Disorder of Childhood
  Gender Identity Disorder of Adolescence, Nontranssexual Type
  Transsexualism - Now code these Gender disorders under Gender Identity Disorder which is placed in the "adult" Sexual and Gender Identity Disorders Section

2. Adult Disorders

Idiosyncratic Alcohol Intoxication - deleted; now code under Alcohol Intoxication
Passive Aggressive Personality - deleted; now code under Personality Disorder NOS
Psychological Factors Affecting Physical Condition - now use V code

B. New Disorders Introduced Into DSM-IV (Excluding Other Conditions That May Be a Focus of Clinical Attention)

1. Child Disorders

Rett's Disorder - under Pervasive Developmental Disorders
Childhood Disintegrative Disorder - under Pervasive Developmental Disorders
Asperger's Disorder - under Pervasive Developmental Disorders
Feeding Disorder of Infancy or Early Childhood - not under another disorder

2. Adult Disorders

Delirium Due to Multiple Etiologies
Dementia Due to Multiple Etiologies
Catatonic Disorder Due to a General Medical Condition
Bipolar II Disorder
Acute Stress Disorder
Sexual Dysfunction Due to a General Medical Condition
Narcolepsy
Breathing-Related Sleep Disorder
Culture-Bound Syndromes (no code number)

3. **New V Codes**

Medication Induced Movement Disorder
Relational Problems
Problems of Abuse and Neglect

10 STEPS TO DIAGNOSIS

The central task of diagnosis is the identification of the major problem. The therapist must listen for the client's presentation of his/her concerns and ask progressively defining questions. For example, someone comes to see the therapist and begins to speak in a very quiet voice, almost whispering. The therapist asks if there is a reason the person is talking so softly. The person may answer "Yes, I'm afraid people outside the office will hear me."

1. Identification of major problem

A. Begin to mentally go through the decision tree
B. What appears to be the major problem? (Ex: suspiciousness)
C. What diagnostic categories share the major characteristic(s)?

2. Begin list #1 (possible diagnosis) e.g.:

A. Substance-Induced Disorder
B. Schizophrenia
    1. Paranoid type
C. Delusional Disorder
D. Dementia
E. Major Depressive Disorder with Psychotic Features
F. Personality Disorder
    1. Borderline
    2. Paranoid

3. Begin list #2 (excluded disorders) e.g.:

A. Anxiety Disorders
B. Somatoform Disorders
C. Sexual Disorders
D. Sleep Disorders
E. Factitious Disorders
F. Impulse Control Disorders
G. Adjustment Disorders

4. Narrow the diagnostic focus

A. Determine Precipitating Factors
  1. Psychosocial factors
  2. Environmental factors

B. Determine Overall Pattern of Problem
  1. Lifelong
  2. Episodic
    a. Duration
    b. Frequency
  3. Degree of severity

5. Modify lists of possible and excluded diagnoses

A. Shorten list #1 - possible diagnoses
B. Add to #2 - rejected diagnoses
C. Begin list #3 - possible diagnoses, not yet checked out

6. Continue to ask questions about each possible diagnosis

7. If the pattern appears lifelong, concentrate on Axis II disorders

8. If the pattern appears episodic or is one-time only, concentrate on Axis I disorders

9. Continue to adjust lists 1, 2, & 3 by using:

A. descriptive information about the problem
B. frequency of problem
C. duration of problem

10. Diagnosis of problem

*(adapted from Othmer & Othmer, 1994)

CHAPTER 5

Treatment Planning

Although managed care companies and some insurance companies focus on short-term therapy, often using Behavioral or Cognitive-Behavioral techniques, it is important to note that Psychodynamic techniques are also used in brief therapy, using very specific, goal oriented treatment plans. Longer-term needs of clients, including affective and intrapsychic issues, that are relevant to problems of the client are addressed in this manual as well as the short-term needs. With all clients, the development of, and active involvement in, community and family support systems should be encouraged when possible.

NOTE: Any part of the treatment planning process that seems difficult has been explained in more detail.

AXIS I
CLINICAL DISORDERS AND OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

1. Disorders usually first diagnosed in infancy, childhood, or adolescence

A. Mental Retardation: (code on Axis II)

Mental Retardation must be documented by an individual IQ test, usually a Stanford Binet or one of the Wechesler family of tests (WISC or WAIS) and an assessment of adaptive functioning.

1. **Theoretical approach:** Behavior Therapy, Play Therapy, Family Therapy

2. **Treatment techniques:** In treating persons with Mental Retardation, there are actually two clients: 1) the Mentally Retarded person and 2) the family of the Mentally Retarded person. Treatment must deal with both. Modified counseling techniques are used. The sessions should be structured, active, and directive. The therapist may use props, games, pictures, or may take walks.

BEST COPY AVAILABLE

The sessions may need to be shortened to one-half hour. Sessions focus on self-esteem, interpersonal relations and self-care. In working with the family, the focus on family issues of loss, grieving, and maintaining healthy dynamics within the family is needed. Decisions may need to be made involving education and residential placement. Siblings of the mentally retarded person are often overlooked, ignored or expected to be "perfect" and may even often "look perfect". In counseling, however, they may be found to be angry, depressed, and disappointed. Family and teachers may need to be taught particular behavior modification programs that include clear expectations and guidelines as well as help to follow the program.

B. Learning and Behavior Disorders

1. Learning Disorders
2. Motor Skills Disorder
3. Communication Disorders
4. Pervasive Developmental Disorders
5. Attention-Deficit and Disruptive Behavior Disorders
6. Feeding and Eating Disorders of Infancy or Early Childhood
7. Tic Disorders
8. Elimination Disorders
9. Other Disorders of Infancy, Childhood, or Adolescence

a. **Medication:** Medication may be used particularly with Attention-Deficit and Disruptive Behavior Disordered clients. However, counseling should be tried first, and only later, if counseling is not successful, should a referral for a medication consultation be made. If medication, usually Ritalin, is prescribed, it should be closely monitored by the therapist.

b. **Theoretical approach:** Behavioral, Cognitive-Behavioral, Psychodynamic, Play Therapy, Reality Therapy, Family Therapy, Parent Training Programs.

c. **Treatment techniques** for these disorders are similar to those of mental retardation; these include the need to structure the counseling sessions to be active, to use props, games, and pictures to help the client better express her/himself. Taking walks, shortening the sessions to one-half hour, listening closely to the client and taking particular note of interests and responses are all very important with these clients. Play Therapy is used with younger children to enable them to express how they feel about themselves and their environment. This technique allows the therapist to understand the client's personality structure and to treat the problems the client is having about her/himself in relation to others. It is important to set up Behavior Modification programs that are do-able and that can be carried out in all appropriate settings. Working with school personnel should be part of the therapeutic approach. With older children Reality Therapy or Psychodynamic Therapy is used. Family involvement is vital in order for the therapeutic work to continue into the home. Appropriate parent training programs should be considered. Family therapy is used, focusing on loss, grief, and the maintenance of healthy family dynamics. The parent or parents may need counseling to help with their own feelings of guilt. Families may also need help with interfacing with the community or school with regard to the client. In their literature review, Roth & Fonagy (1996) note that: "The appropriate therapy depends on the form and severity of presentation, though more structured interventions based on theoretical models appear more effective than generic counseling" (p. 367). Specifically, they found the following interventions to be most helpful with children:

- Behavior modification for enuresis and encopresis
- Parent training programs and cognitive-behavioral therapy for oppositional behavior
- Rapid exposure for school phobia
- Cognitive-behavioral treatment for GAD (Generalized Anxiety Disorder) (promising/limited effectiveness)
- Psychodynamic psychotherapy for GAD (promising/limited effectiveness)
- Exposure and response prevention for OCD (promising/limited effectiveness)
- Structural family therapies for disruptive disorders (promising/limited effectiveness)
- Long-term multimodal therapy for ADHD (promising/limited effectiveness)
- Family therapy for psychophysiological disorders
- Psychodynamic psychotherapy for psychophysiological disorder (promising limited effectiveness)
- Contingency management treatment of undesirable behavior in pervasive developmental disorders (Roth & Fonagy, 1996, p. 367)

2. Delirium, Dementia, and Amnestic and Other Cognitive Disorders:

In this group of disorders, safety of the client is paramount.

A. **Delirium** is a "disturbance of consciousness and a change in cognition that develop over a short period of time" (DSM-IV, p. 123). It is a medical emergency and safety of the client is the first priority.

1. **Medication:** Haloperidol is often used for the agitation.

2. **Theoretical approach:** Psychoeducational, Cognitive

3. **Treatment techniques:** These clients should be followed closely by a neurologist and a psychiatrist. The psychotherapist may not be the primary treatment person, since the client's medication and safety needs may take precedence. Psychological support during and after a delirium is important. Counseling is very structured and is focused particularly on helping the client understand the bizarre experience, helping her/him talk about it (if the client remembers it). Explanation and education helps reduce the likelihood of posttraumatic symptoms. Explanation to the family about delirium helps reduce anxiety and calm fears.

B. **Dementia** is a syndrome that includes both deterioration of intellectual ability and alterations in the client's emotional and personality functions. The causes are Alzheimer's disease, vascular dementia, general medical conditions or multiple etiologies.

1. **Medication** is usually directed toward the particular symptoms.

2. **Theoretical approach:** Psychoeducational, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** These clients also should be followed closely by a neurologist and a psychiatrist. Again, the psychotherapist may not be the primary treatment person. Teaching strategies for enhancing memory can help. Working with the client regarding the feelings of loss of cognitive faculties is also important.

C. **Amnestic Disorders** are characterized by disturbances in memory caused by the direct effects of a general medical condition or the persisting effects of a substance. The substance may be a drug of abuse, medication, or a toxin.

1. **Medication:** None is prescribed for this disorder.

2. **Theoretical approach:** No approach has been shown to be consistently successful. Cognitive-Behavioral Therapy has had some success.

3. **Treatment techniques:** The use of a real-life, problem-oriented approach may help in teaching these clients particular strategies for enhancing memory or working around memory gaps. Use of external aids to solve the problems of everyday life, including use of a memory book, keeping a daily calendar or memory board have been tried. Teaching clients to remember to use the aids (prospective memory) is another problem not yet completely resolved. Targeting treatment to the underlying etiology of the disturbance is important.

3. Mental Disorders Due To a General Medical Condition

Some mental disorders are the direct consequence of a medical condition. The medical condition, itself, must be coded on Axis III. Disorders included are:

- Catatonic Disorder Due to a General Medical Condition
- Personality Change Due to a General Medical Condition
- Mental Disorder Not Otherwise Specified Due to a General Medical Condition (incl.: Mental Disorder Not Otherwise Specified Due to HIV Disease)

A. **Medication:** may be prescribed for the physical condition and psychotropic medication may be needed.

B. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic

C. **Treatment techniques:** The client should be followed closely by a physician. Psychotherapy should include coping with the medical condition and behaviors that may need to be changed. The client may also need to deal with feelings of loss surrounding the medical condition and responses to the client by family, friends or the general public.

4. Substance-Related Disorders including:

- Alcohol-Related Disorders
- Amphetamine-Related Disorders
- Caffeine-Related Disorders
- Cannabis-Related Disorders
- Cocaine-Related Disorders
- Hallucinogen-Related Disorders
- Inhalant-Related Disorders
- Nicotine-Related Disorders
- Opioid-Related Disorders
- Phencyclidine-Related Disorders (PCP)
- Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

A. **Medication:** may be used, particularly during detoxification.

B. **Theoretical approach:** Psychoeducation, Behavioral, Cognitive, Group, Family, Psychodynamic

C. **Treatment techniques:** Found most effective: behavioral therapy aimed at increasing social adaptation including social skills training, marital therapy, and community reinforcement packages as well as brief educational interventions, including motivational interviewing, (Roth & Fonagy, 1996). Also used are: group counseling, participation in AA/NA, and family counseling to help support changes. Individual counseling helps the client integrate all the aspects of the other therapeutic interventions. See section on Substance Use Disorders in this manual.

5. Schizophrenia and Other Psychotic Disorders

A. Schizophrenia

1. **Medication:** Medication is the primary mode of treatment, usually a neuroleptic for the psychotic symptoms. Consistent medical management is necessary.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral, Group, Psychodynamic, Family

3. **Treatment techniques:** Family intervention programs are found to be the most effective treatment (Roth & Fonagy, 1996). The psychotherapist works with family members to help them understand the nature of the disorder and assists them in moderating their own behavior (particularly criticism) to reduce the possibility of a recurrence or relapse. Cognitive therapy has been found effective for delusions. Individual therapy is used and is supportive to help the client deal with skills of daily living and increase social skills. Emphasis on medication compliance is important.

B. Schizophreniform Disorder

1. **Medication:** Use depends on the severity and duration of the episode as well as other factors such as: risk of suicide or homicide, previous episodes, family history, premorbid level of functioning. Neuroleptic medication is used. Medication is the primary mode of treatment.

2. **Theoretical approach:** Psychoeducation, Family, Group (however, if client is concerned about prognosis, he/she may become frightened in a group if chronic schizophrenic clients are participating)

3. **Treatment techniques:** Treatment of the acute symptoms of Schizophreniform Disorder is the same as treatment of the acute symptoms of Schizophrenia. Psychoeducation is focused on the disorder and the necessity of maintenance of neuroleptic medication. This disorder lasts for at least 1 month but less than 6 months. If symptoms persist after 6 months, the diagnosis changes to Schizophrenia.

C. Schizoaffective Disorder

1. **Medication:** Management of the acute phase usually consists of neuroleptic medication for the psychotic symptoms, lithium or another mood stabilizer for the manic or mixed symptoms, and an antidepressant for depressive symptoms. Ongoing medication management is often unclear.

usually focused on the target symptoms and what is judged to be helpful for a particular client. Medication is the primary mode of treatment.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral, Family

3. **Treatment techniques:** The techniques used with these clients depend upon whether the disorder is in the schizophrenic or the affective phase. Psychoeducation focuses on identification of early symptoms, reduction of stress and medication compliance. Focus on daily living and social skills is important as well as helping the client and family understand and cope with the disorder.

D. Delusional Disorder

1. **Medication:** Neuroleptic medication is usually used for the delusions along with an antidepressant if prominent mood symptoms are also present.

2. **Theoretical approach:** Cognitive

3. **Treatment techniques:** Gentle probing of the client's delusional thinking sometimes results in improved reality testing. Confrontation may impair the therapeutic relationship, increase anxiety and promote further decompensation. However, not confronting the delusional thinking can result in the client thinking the therapist believes the fears are real, thus making the client more frightened. Medication compliance is important to stress.

E. Brief Psychotic Disorder

1. **Medication:** Neuroleptics are used for the psychotic symptoms. Medication is the primary mode of treatment, initially. Duration of medication once the psychotic symptoms have subsided varies depending on such issues as: duration and severity of symptoms, presence of suicidal or homicidal impulses, likelihood of response to early signs of relapse, the possibility of the presence of a mood disorder.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Supportive psychotherapy focuses on helping the client cope with, or be removed from, the stressor, if there is one. There should be an emphasis on ways in which life-style changes may be helpful in preventing a recurrence. The duration of this disorder is at least one day, but less than one month. If the symptoms persist beyond one month, the diagnosis is Schizophreniform, if there is no mood disorder apparent. If a mood disorder is apparent, the diagnosis is either Bipolar Disorder or Schizoaffective Disorder.

F. Shared Psychotic Disorder (Folie a Deux)

1. **Medication** is generally used only if there is psychotic ideation, at which point medication for the specific psychosis is prescribed.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Treatment usually involves coupling treatment of the inducer's disorder, using standard methods, and separation of the dyadic partners. If the delusional beliefs do not diminish in intensity or disappear, upon separation, another diagnosis should be considered. If the person with this disorder is a child, separation may involve a foster care placement or

otherwise transferring dependencies. Encouraging autonomy and independence in both partners is important, particularly if separation is not possible.

G. Substance-Induced Psychotic Disorder

1. **Medication:** Hospitalization may be necessary in the acute stage. Neuroleptic medication is often necessary on a short-term basis.

2. **Theoretical approach:** If there is no major psychiatric illness, treatment of the substance is appropriate (Psychoeducation, Behavior, Cognitive, Group, Family, Psychodynamic). If there is concomitant major psychiatric illness (Dual Dianosis), Psychoeducation and Cognitive-Behavioral approaches are used.

3. **Treatment techniques:** Dealing with the inducing substance is the first priority, followed by attention to the possible risks associated with the psychotic beliefs. The therapist must prevent clients from hurting themselves or others in response to the psychotic thinking. The client must be removed from the environment in which substances are available.

Dual Diagnosis refers to the coexistence of a major psychiatric illness and substance dependence and/or abuse.

If the client falls into the Dual Diagnosis category (if there is truly a major psychiatric illness in addition to the substance abuse), effective treatment must address both the medical and psychiatric needs, as well as the client's social and material needs. Case management of a system of treatments and supports is helpful. Substance Abuse programs, in general, may not be appropriate since these clients may be too vulnerable to regression and relapse.

6. Mood Disorders

A. Major Depressive Disorder

1. **Medication:** Antidepressants, MAO inhibitors. Hospitalization may be necessary. With Psychotic Features: antipsychotics in combination with antidepressants

2. **Theoretical approach:** Found to be most effective: Cognitive-Behavioral and Interpersonal. Psychodynamic is also used with some success.

3. **Treatment techniques:** Psychotherapy is the major treatment with clients who exhibit mild or moderate symptoms. The focus of the therapy is to help clients change their disordered thinking and behavior. Techniques of interpersonal therapy help to enhance the social functioning of these clients. Pharmacotherapy may provide rapid, relief from acute distress, while psychodynamic therapy provides broad and enduring change. Psychotherapy combined with medication retains the specific benefits of each, and is used successfully, particularly with severely depressed clients.

With Melancholic Features: May need treatment for somatic symptoms, using reality-testing and connecting the symptoms with the anxiety/stress.

B. Dysthymic Disorder

1. **Medication:** Antidepressants may be used, although the response is lower than for clients with most other Mood Disorders.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic, Interpersonal

3. **Treatment techniques:** The combination of medication and psychotherapy may be helpful with this group of clients. Other treatment techniques are similar to those with Major Depressive Disorder.

C. Bipolar I Disorder

". . . a clinical course that is characterized by the occurrence of one or more Manic Episodes or Mixed Episodes. Often individuals have also had one or more Major Depressive Episodes" (DSM-IV, pp. 350–351).

1. **Medication:** Mood-stabilizing medication is used, particularly Lithium, which needs to be monitored closely. Lithium may also predispose the client to manic episodes and rapid cycling which would indicate use of alternative mood-stabilizing medication (Gabbard, 1996).

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Treatment consists of treating the acute mania, and acute depression, prevention of manic and depressive recurrence. This disorder is almost always recurrent. The therapeutic alliance with these clients is essential. Providing explicit detailed instructions and education about the illness and its treatment, and discussing the anticipated problems in management will help establish this alliance. Charting mood, sleep patterns and treatment on a daily basis and incorporated into a monthly chart is helpful. A treatment plan for each phase of the illness, agreed to by both client and therapist is important.

D. Bipolar II Disorder

". . . a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. . . . the presence of a Manic or Mixed Episode precludes the diagnosis of Bipolar II Disorder" (DSM-IV, p. 359) (and is then diagnosed as Bipolar I Disorder).

1. **Medication:** Mood-stabilizing medications may be needed on a maintenance regimen. Antidepressants should be used cautiously since a manic episode may develop and/or the client may develop rapid cycling.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Clients and families should receive psychoeducation about the nature of the disorder. Cognitive-Behavioral techniques should include training in life-stabilizing techniques and recognizing any early signs of relapse.

E. Cyclothymic Disorder

1. **Medication:** Mood-stabilizing medications and/or antidepressants are often used.

2. **Theoretical approach:** Psychoeducation, Cognitive-Behavioral

3. **Treatment techniques:** Psychoeducational techniques, focusing on encouraging the client to lead as stable a life as possible and to avoid substance use, are helpful. Stability and avoidance of

substance use helps with any internal mood swings, keeping the external world as stable and predictable as possible. Cognitive-Behavioral techniques can also be helpful in maintaining stabilization.

F. Mood Disorder Due to a General Medical Condition

1. **Medication:** Medication for the General Medical Condition may be necessary. Use of an antidepressant or mood-stabilizer may be needed for affective symptoms.

2. **Theoretical approach:** Cognitive-Behavioral, Psychodynamic (particularly Interpersonal), Behavioral Therapy

3. **Treatment techniques:** Many depressive states in clients with medical problems are *not* actually symptoms due to the direct physiological effects of an underlying general medical condition, but may occur *concomitantly* with the medical condition. Those clients should be treated under the appropriate affective diagnosis. The present diagnosis is used only when the mood symptoms are the *direct consequence* of the general medical condition and are clinically significant, such as: fibromyalgia, Huntington's Disease, multiple sclerosis, anorexia nervosa, schizophrenia, HIV, diabetes, brain tumor, stroke, coronary heart disease, asthma, sleep apnea, arthritis. Treatment of the mood symptoms in this disorder are similar to treatment of mood disorders in other diagnoses: focus on disordered thinking and behavior as well as any interpersonal problems.

G. Substance-Induced Mood Disorder

1. **Medication:** With agitated clients, a benzodiazepine may be helpful to control the agitation. If psychosis persists more than 24 hours, a low dose neuroleptic may be necessary. Some psychoses may remit spontaneously following cessation of the drug use. Psychopharmacological medication may be necessary if the mood or anxiety disorder persists for more than a month.

2. **Theoretical approach:** Psychoeducational, Psychosocial, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Safety of the client is paramount and hospitalization may be necessary. Initial treatment should be targeted to the Substance Abuse or Dependence. Mood symptoms may be present following detoxification at which time medication and/or psychotherapy is needed, depending on the mood disorder.

7. Anxiety Disorders

It is important to be as integrative as possible regarding the various treatments for this group of disorders.

A. Panic Disorder

1. **Medication:** Tricyclic antidepressants, serotonin reuptake inhibitors, MAO inhibitors, high-potency benzodiazapines, anticonvulsants may by used in some complicated cases.

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychoeducation, Psychodynamic

3. **Treatment techniques:** Reduction of client's fears, helping a client to understand her/his physical complaints (may use breathing retraining or relaxation techniques, since hyperventilation is often related to many of the symptoms), helping client with her/his misunderstanding of bodily sensations (Cognitive), desensitization techniques, exposure therapy (Behavioral), generally will reduce a client's fears. Combined antidepressant and behavioral treatment may also be especially effective with these clients. Exploring unconscious triggers of panic symptoms (often fear of separation/abandonment) (Psychodynamic) can be helpful. Couples therapy can be especially helpful in some cases.
   With agoraphobia - necessitates treatment for the avoidant behavior. Cognitive-Behavioral approaches particularly using exposure to the feared situations has been found to be the most effective.

B. Specific Phobia

This disorder often accompanies other (perhaps more severe) psychiatric diagnoses. The clinician should make sure the presenting symptomatology is best categorized as a Specific Phobia rather than as Panic Disorder or another diagnosis.

1. **Medication:** Beta-blockers and benzodiazepines may reduce some symptoms.

2. **Theoretical approaches:** Behavioral, Psychodynamic, Psychoeducation

3. **Treatment techniques:** Behavior therapy, consisting of exposure-based therapy (found to be the most efficacious by Roth & Fonagy, eds., 1996), systematic desensitization, relaxation exercises and participant modeling are generally the treatments of choice for uncomplicated specific phobia. Psychodynamic therapy, Psychoeducation, including support and relaxation exercises, may all diminish fear and anxiety, instill hope and a sense of self-efficacy, and facilitate exposure to avoided situations.

C. Social Phobia

1. **Medication:** MAO inhibitors, benzodiazepines, beta-adrenergic blockers

2. **Theoretical approaches:** Cognitive, Behavioral, Cognitive-Behavioral, Psychodynamic (Interpersonal), Group

3. **Treatment techniques:** Cognitive therapy combined with exposure has been found to be the most effective with these clients (Roth & Fonagy, 1996). Also used are cognitive-behavioral techniques of social skills training and relaxation strategies. Cognitive-behavioral group therapy has been used successfully. Interpersonal therapy, aims to diminish disabling fears and anxieties about social embarrassment, shame and rejection. Interpersonal therapy also helps the client overcome avoidant behaviors and have more successful interpersonal experiences.

D. Obsessive-Compulsive Disorder:

Careful diagnosis is very important since clients may hide their symptoms or symptoms may be complicated by comorbid conditions.

1. **Medication:** SRIs, particularly clomipramine; SSRIs: Prosac, Zoloft, Paxil

2. **Theoretical approaches:** Behavioral, Cognitive, Rational Emotive, Psychodynamic

3. **Treatment techniques:** Exposure and response prevention techniques have been found to be the most successful with clients with OCD (Roth & Fonagy, 1996). These therapies are also used with potent SRIs. Cognitive restructuring and rational emotive therapies in combination with exposure therapy have also been found to be successful. The therapist may decide with the client to use psychotherapy, medication or a combination of the two, depending on the severity of the disorder. Clients with mild or moderate symptoms may benefit from cognitive-behavioral approaches alone. A combination of psychotherapy and medication is usually indicated for clients with moderate to severe symptoms. Relapse is often rapid when potent SRIs are discontinued (Gabbard, 1996).

E. Posttraumatic Stress Disorder:

It is important to assess the client for Panic Disorder and Major Depressive Disorder, since they may coexist with PTSD.

1. **Medication:** Antidepressants, MAOIs

2. **Theoretical approaches:** Psychoeducation, Cognitive-Behavioral, Psychodynamic

3. **Treatment techniques:** Stress reduction therapy in combination with cognitive and exposure techniques and applied relaxation have been found to be successful with clients with PTSD. Structured psychodynamic therapy is also successful (Roth & Fonagy, 1996). The client should be helped to understand his/her present symptoms and others that may be likely to occur, including intrusive thoughts, nightmares, startle reactions and physiological triggers. As these symptoms become less terrifying the client may enable to expect reactions that may then have less impact. Treatment should include not only the above mentioned techniques, but also behavioral exposure. Psychodynamic therapy can include group therapy which can be helpful. It is important to help the client regain a sense of control over her/his life.

F. Acute Stress Disorder

1. **Medication:** Propranolol, clonidine, benzodiazepines (unless there is a history of alcoholism)

2. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Hypnosis may be helpful

3. **Treatment techniques:** Treatment is based on a crisis intervention model, focusing on rapid reduction of present symptoms and prevention of later illness. Psychotherapy should begin as soon after the trauma as possible. The opportunity for the client to process the traumatic event(s), assisting him/her in integrating the experience into his/her sense of self and the world, is needed. The therapist needs to be sensitive about the traumatic event(s) and provide the supportive environment needed to cope with the traumatic events. Contextual factors surrounding the similarly affected are used in regular group therapy or in "mini-marathon groups" of about 3 hours per session within structured group meetings. Such groups enable the client to obtain social support in coping with the trauma.

G. Generalized Anxiety Disorder

1. **Medication:** Antidepressants, benzodiazepines

2. **Theoretical approaches:** Cognitive-Behavioral, Behavioral

3. **Treatment techniques:** Cognitive-behavioral therapy has been found to be most successful with these clients (Roth & Fonagy, 1996). Techniques include methods that focus on identifying the cognitive responses that are contributing to anxiety (thoughts, interpretations, meanings, predictions, beliefs), and then systematically questioning whether these cognitions are based on reality. Behavioral techniques used for these clients are: self-monitoring, relaxation, exposure methods (i.e., invivo, imagery-based). Since the anxiety these clients experience is a product of several interacting systems, a combination of these interventions, each targeting different aspects of the system, may offer great benefit. Pharmacotherapy should be considered when symptoms are severe or when psychological interventions are not feasible.

8. Somatoform Disorders

A. Somatization Disorder

1. **Medication:** None is generally used.

2. **Theoretical approaches:** Combination of Psychodynamic, Psychoeducational

3. **Treatment techniques:** These clients are generally difficult to treat. The therapist and physician work together to reassure clients that their physical symptoms are not being ignored, while carefully bringing attention to their emotional problems. The relationship between anxiety and physical symptoms must be addressed. Management of clients with this disorder may be long-term supportive psychotherapy that includes an important sympathetic relationship.

B. Conversion Disorder

1. **Medication:** Amobarbital may be used to alter defenses (esp. repression), to allow relaxation and to facilitate the gathering of more historical information. Medication for any depression may be used.

2. **Theoretical approaches:** Hypnosis (since this disorder tends to occur to people who can be suggested into [and out of] symptoms), Behavioral therapy, Supportive therapy, Physical therapy, Biofeedback, Speech therapy, Environmental Intervention may be helpful. Insight oriented therapies generally are not helpful.

3. **Treatment techniques:** Conversion disorder often occurs because of psychosocial stressors in susceptible persons who have difficulty articulating their distress. Thus the therapist must decode the disguised communication and develop a treatment plan which addresses the specific needs of each client. Environmental stressors and possible concurrent psychiatric disorders must be considered. It is generally helpful to coordinate the various therapeutic modalities, psychotherapies, behavior modification techniques and other therapeutic interventions, while reducing the reinforcement of the symptom and providing a face-saving opportunity for the client to relinquish the symptom.

C. Pain Disorder

1. **Medication:** Anti-inflammatory medication (for mild to moderate and other acute pain), antidepressants, analgesics (for moderate to severe pain), benzodiazepines.

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral

3. **Treatment techniques:** Operant conditioning is used to reinforce positive ("healthy") behaviors and reduce self-defeating behaviors. Cognitive-Behavioral therapy focuses on identifying and correcting the client's distorted attitudes, beliefs, and expectations; helping her/him become more aware of factors that exacerbate and diminish pain and modifying her/his behavior (cognitive restructuring). Techniques used may be biofeedback, relaxation training, hypnosis, distraction, stress management, activity pacing, sleep management. The therapist may help the client plan strategies for dealing with the pain.

D. Hypochondriasis

1. **Medication:** Antidepressants, Benzodiazepines (temporary)
2. **Theoretical approaches:** Cognitive-Behavioral, Educational, Supportive
3. **Treatment techniques:** Few controlled studies have been done on the most efficacious forms of treatment for these clients. However, some researchers are exploring new ways of treating hypochondriasis on the assumption that this problem is largely learned behavior. The objective of treatment is to replace maladaptive responses or habits with ones that are more adaptive. Reassuring the client of the benign nature of their symptoms along with efforts to correct their misperceptions about anatomy, physiology, and neurology may be helpful. Reassurance must take into account the client's previous experiences, reassurance-seeking behavior, personality factors, and need for a trusting, dependable relationship with the clinician. An understanding of transferential and countertransferential responses that can be used in therapeutic interventions is probably helpful.

E. Body Dysmorphic Disorder

1. **Medication:** Antidepressants (fluoxetine or clomipramine if depression is part of the presentation - also useful if OCD or social phobia coexist as is often the case).
2. **Theoretical approaches:** Cognitive-Behavioral
3. **Treatment techniques:** Treatment may take a relatively long time and dosages of medication may need to be higher than is generally needed for depression. Cognitive-behavioral techniques used may be: exposure therapy, response prevention, self-esteem building, cognitive restructuring, developing coping strategies. These techniques are especially helpful when combined with medication.

9. Factitious Disorders

A. Factitious Disorder (may be called Munchausen Syndrome)

1. **Medication:** Antidepressants may be effective with depressed clients. Neuroleptic medication may be used judiciously.
2. **Theoretical approaches:** Cognitive-Behavioral, Reality, Psychodynamic
3. **Treatment techniques:** Confrontational interventions have been used with limited success. Nonconfrontational treatment also has limitations since some clients feel they are in

life-threatening situations and authoritative interventions are needed immediately. It may be helpful to give the client an opportunity to relinquish his/her factitious disorder or to admit it with "face saving" techniques, such as offering a double-bind situation, or hypnosis or biofeedback. The client may accept these techniques more readily than overt psychotherapy and may feel comfortable talking about significant psychological issues. Psychodynamic therapy can be used with some clients.

B. Factitious Disorders Not Otherwise specified

1. Munchausen Syndrome by Proxy (MSP)

a. **Medication:** None

b. **Theoretical approaches:** The following therapies may be helpful, however there are few outcome studies for this diagnosis. For the person perpetrating the factitious disorder, usually the mother: Behavioral, Family therapy. For the child: Behavioral, Family therapy, Supportive therapy. For both mother and child: Creative treatment plans including Family therapy and Supportive therapy.

c. **Treatment techniques:** The mother is often mandated to psychiatric treatment. Outcome data to predict effectiveness of this mandated treatment is very limited. The child (if old enough) may need individual therapy because of the mother's actions. Treatment intervention necessitates close coordination between multiple agencies. If an older child accuses his/her father of sexual abuse, it is important to remember that there is an increased incidence of false claims of sexual abuse in cases of MSP. The mother often initiates these claims, especially if a divorce is a possibility.

2. Malingering

a. **Medication:** None

b. **Theoretical approaches:** Cognitive-Behavioral, Creative approaches

c. **Treatment techniques:** The secondary gain of some external benefit is usually greater than the secondary costs with these clients. A primary gain is often associated with it as well. Identifying the stressors, cognitive restructuring, identifying the gains and reframing may be helpful. These clients require creative approaches to treatment. Few studies are available which indicate "successful" treatment approaches or techniques. Diagnosis may be difficult even for experienced therapists.

10. Dissociative Disorders

A. Dissociative Amnesia

1. **Medication:** None except for drug-facilitated interviews

2. **Theoretical approaches:** Hypnosis, Cognitive-Behavioral, Supportive, Group

3. **Treatment techniques:** The first priority is to establish safety and stabilize the client, then attempt to take a history of the trauma while assuring the client that he/she *can* remember when

he/she is ready - at the client's own pace without needing to remember all the details or information at one time. *Permissive suggestions* for recall is a very important factor, although hypnosis may be helpful. Help the client to develop an organizing framework for understanding her/his symptoms and an understanding of the treatment process. Help the client return to awareness of her/his identity and general personal circumstances. The client may need to be "grounded", literally, by opening his/her eyes and looking around, touching his/her feet or the floor, breathing deeply, etc. The client may need concrete orientation to time and circumstances. The client may also experience PTSD or DID symptoms which would indicate treatment for those symptoms.

B. Dissociative Fugue

These clients may also present memory disturbances including local and/or generalized amnesia.

1. **Medication:** None except for drug-facilitated interviews
2. **Theoretical approaches:** Hypnosis, Cognitive-Behavioral, Family therapy
3. **Treatment techniques:** Since these clients may have traveled far from home (although rarely), appeals to the local media may not alert the client's significant others. The client may resist uncovering his/her actual identity. Family therapy and social service interventions may be necessary to help resolve the complex issues. Treatment techniques used for Dissociative Amnesia are used with Dissociative Fugue as well.

C. Dissociative Identity Disorder (formerly Multiple Personality Disorder)

1. **Medication:** None has been found to have a specific impact. However, coexisting conditions or needs may indicate the need for medication for particular conditions.
2. **Theoretical approaches:** Psychodynamic, Cognitive, Behavioral, Hypnosis, Family therapy - no one model of treatment provides an ideal guide for all the situations and circumstances the clinician may encounter.
3. **Treatment techniques:** DID is, in itself, controversial. There are also many strongly held and often polarized opinions on treatment. Whether DID should be treated at all is controversial. Treatment may (1) focus on integration of the personalities by resolution of dissociative defenses and structures (strategic integrationalism), (2) attempt to bring about integration, but conduct the therapy based on employing skillful, discrete interventions toward a series of tactical therapeutic objectives (tactical integrationalism) (3) be personality-based where there is a belief that dividedness is not problematic or that the personalities need to be nurtured into health (personality-focused treatments) or (4) behavior based focusing on the belief that management of life activities is most important and integration is a secondary goal (adaptationalism). More than one session per week or one longer than normal session is often needed.

   Treatment recommendations associated with good clinical results include: establishing consistent boundaries; focusing on mastery; client participation in treatment (therapeutic tasks may be assigned on a regular basis); establishing a strong therapeutic alliance; working with an "inaccurate memory" to uncover actual material; working with the separateness and conflict of the "alters" (personalities) to emphasize collaboration, cooperation, empathy, and identification among them to diminish conflicts; using simple and direct sentences; approaching issues slowly;

being evenhanded to all alters and not "playing favorites". Therapy should work toward restoring morale and increasing realistic hope. Pace the therapy so it does not become overwhelming. The clinician must be very responsible and hold the client to high standards of responsibility (when reasonable responsibility is understood). The clinician should be less technically neutral, and exhibit warmth to allow for a latitude of affective expression. Correct cognitive errors by gently creating cognitive dissonance about irrational beliefs (in Gabbard, 1995).

D. Depersonalization Disorder

1. **Medication:** The following medications have been used with some success: antidepressants, clozapine (antianxiety), clonazepam (neuroleptic)

2. **Theoretical approaches:** Cognitive, Psychodynamic, Psychoeducation, Family therapy (particularly with the coexistence of DID), Group therapy

3. **Treatment techniques:** Psychotherapy should focus on symptom exploration, reduction of traumatic memories, client education, and self-work. Techniques used are: education regarding the symptom, its development and available treatment; exploration of possible triggers of episodes. The following are used for symptom reduction: "grounding" or reorienting techniques, distraction techniques, controlled dissociation, creative visualization.

11. Sexual and Gender Identity Disorders

The etiology of some sexual disorders are organic factors, medical disorders or medications prescribed for the medical problem, psychotropic medications or substance use. The presence of any of these conditions informs the treatment planning.

A. Sexual Dysfunctions

1. Hypoactive Sexual Desire Disorder

a. **Medication:** Xanax, Desyrel (other antianxiety medications are less useful because of their possible sexual side effects)

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Strategies that focus on increasing sexual desire (libido enhancement) in preparation for lovemaking include client's use of erotic fantasy, reading or looking at explicitly erotic material or lightly stimulating his/her own genitalia. The incorporation of these sexually arousing strategies in conjunction with psychotherapy is a unique feature of the psychodynamically oriented sex therapy approach. Cognitive-behavioral interventions focus on systematic, gradual, in-vivo exposure from client-related to partner-related genital stimulation. Techniques include: dating assignments, sex education, sexual skills training, encouragement of genital stimulation, "stay with the pleasure" assignments.

2. Sexual Aversion Disorder

a. **Medication:** Xanax, DeSyrel (other antianxiety medications are less useful because of their possible sexual side effects).

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Psychodynamic approaches focus on the elimination or improvement of the high anxiety, panic or phobic aversions which result in the client's sexual panic states. This approach consists of an integrated amalgam of cognitive-behavioral homework assignments that are used to modify the immediate causes of the client's sexual dysfunction and management of the client's resistances in office sessions. Cognitive-behavioral interventions (as in Hypoactive Sexual Desire) focus on systematic, gradual, in-vivo exposure of the client to partner-related genital stimulation, but in Sexual Aversion Disorder the focus is on that specific aspect of sexual behavior that triggers her/his phobic avoidance or revulsion. Comorbid disorders may also exist with this diagnosis which would need attention.

B. Sexual Arousal Disorders

1. Female Sexual Arousal Disorder

a. **Medication:** None

b. **Theoretical approaches:** Psychoeducational, Cognitive-Behavioral, Psychodynamic, Systems approaches

c. **Treatment techniques:** Familiarity with a variety of treatment approaches is needed, including knowledge of the underlying principles involved. Strategies involve: 1) encouraging the most comfortable conditions possible in which to experience a natural sexual response, 2) maximizing stimulation, 3) minimizing inhibiting influences. Treatment should be flexible and individually tailored. Techniques can include: general body exploration, genital self-examination, total body pleasuring exercises, genital pleasuring exercises, focused masturbation to orgasm, strengthening the pubococcygeal muscle, stress reduction techniques, relaxation exercises, self-hypnosis, meditation, the body scan (scanning various parts of the body), guided fantasy, erotic literature or films, keeping a sexual diary, play-acting orgasm, as examples.

2. Male Erectile Disorder

a. **Medication:** None

b. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychodynamic, (incl. Interpersonal), Systemic approaches, Psychoeducational

c. **Treatment techniques:** The aims of therapy are: 1) to enhance sexual arousal, 2) to decrease anxiety regarding sexual performance, 3) to address the issues preventing resolution of the erectile dysfunction that limits sexual satisfaction (including cognitive, psychodynamic, relational). Behavioral and cognitive-behavioral treatments have been found to be the most effective (Roth & Fonagy, eds., 1996). Techniques include: accurate information about sexuality that dispel possible myths or inaccurate beliefs, systematic desensitization, relaxation, cognitive restructuring, reframing, modification of maladaptive sexual attitudes, and working through unconscious conflicts. Interpersonal, systemic and psychoeducational techniques are also used at various stages in the treatment.

C. Orgasmic Disorders

1. Female Orgasmic Disorder

a. **Medication:** None

b. **Theoretical approaches:** Psychoeducational, Cognitive-Behavioral, Psychodynamic, Systems approaches

c. **Treatment techniques:** Each client needs to be evaluated on her own characteristics. Treatment techniques described in Female Sexual Arousal Disorder (explained above) are applicable with Female Orgasmic Disorder diagnosis, with attention given to an individually tailored treatment plan.

2. Male Orgasmic Disorder

a. **Medication:** None

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Little study has been done on this disorder, but the following is the standard treatment strategy: eliminate performance anxiety and ensure adequate levels of physical stimulation. The couple is instructed to caress the penis manually (and orally, if acceptable), until erection is attained, then cease stimulation whenever arousal is approaching the point of impending orgasm, reducing the goal-focused anxiety about performance and allowing the man to just enjoy the sexual pleasure. When orgasm is occurring reliably in this manner, the same procedure is used during intravaginal intercourse. If the client presents with life-long and global inhibited orgasm, treatment should begin with the client learning to masturbate.

3. Premature Ejaculation

a. **Medication:** None

b. **Theoretical approaches:** Behavioral (treatment of choice, Roth & Fonagy, eds., 1996)), others used: Cognitive, Psychodynamic, Educational

c. **Treatment techniques:** The goal is to increase the amount of time the man can be aroused without needing to pause. Stop-start or pause procedure (Semans, 1956) is recommended where the penis is manually stimulated until the man is fairly highly aroused. The couple then pauses until the man's arousal subsides, at which time the stimulation is resumed. This series is repeated several times before stimulation is carried through to ejaculation, so the man ultimately experiences much more total time of stimulation than he ever has before, thus learning to have a higher threshold for ejaculation. (This treatment strategy is explained further in Gabbard, 1995, Vol. II.) Also used are behavioral and cognitive-behavioral techniques aimed at reducing sexual anxiety and improving communication concerning the premature ejaculation.

D. Sexual Pain Disorders

1. Dyspareunia

a. **Medication:** None

b. **Theoretical approaches:** Behavioral, Cognitive, Psychodynamic (Interpersonal)

c. **Treatment techniques:** Treatment usually involves the client and his/her partner, seen both together and individually. Assignments include learning to relax and control vaginal dilation and penetration. Challenging unrealistic or unexplored cognitive beliefs and assumptions is important. The man may experience postejaculatory pain syndrome. If so, an organic cause may be determined with appropriate treatment begun. Interpersonal dynamics usually need attention.

2. Vaginismus

a. **Medication:** None

b. **Theoretical approaches:** Psychodynamic, Behavioral

c. **Treatment techniques:** The goal is the extinction of the conditioned vaginal response. Treatment includes: exposure (in fantasy and reality) to the feared situation (the most effective according to Roth & Fonagy 1996) while keeping anxiety at a minimum and providing reasonable reassurance and support. In the psychodynamic approach it is also important to understand the conflicts the woman may be having regarding sexuality, femininity and mature womanhood. Muscle relaxation or desensitization and gradual insertion of objects of increasing size into the vagina under conditions of relaxation and client control are also used in treatment.

E. Paraphilias

(not including Pedophilia or Transvestic Fetishism)

1. Exhibitionism
2. Fetishism
3. Frotteurism
4. Sexual masochism
5. Voyeurism

Similar strategies can be used for all the above paraphilias

a. **Medication:** Testosterone-lowering medications: Cyproterone acetate (CPA), Medroxyprogestrone acetate (MPA), Leuprolide acetate (LPA). The usefulness of antiobsessional medications (e.g.: clomipramine) and other medications is being studied (Gabbard, 1995, Vol. II).

Surgical intervention: castration has been used with a generally low recidivism rate, though it is not condoned for ethical reasons. Stereotactic neurosurgery (making a microscopic lesion at a specific brain site) is considered experimental.

b. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Psychoeducational, Group therapy

c. **Treatment techniques:** Treatment addresses unresolved conflicts responsible for sustaining a paraphilia (including possible developmental issues). Relapse prevention uses strategies used with drug and alcohol addiction. Behaviorists may use forms of aversive therapy, as well as masturbation satiation, and thought blocking. Cognitive-Behavior therapy is used in cognitive restructuring. Specialized group counseling where clients can discuss their sex-related problem (it may be the only place where this is possible for them) can be useful. The group can provide encouragement and support as well as confront denial, minimization and rationalization and provide a forum for teaching relapse prevention strategies. The group strategies may use several models: insight-oriented, cognitive-behavioral, relapse prevention, social skills training. If a client is at high risk of relapse, brief hospitalization may be recommended. Whatever the methods used, documentation of outcome is critical.

2. **Pedophilia**

a. **Medication:** Serotonin reuptake inhibitors, hormonal agents are used. If the behavior is concomitant with a psychotic illness or major depression, drug intervention, hospitalization or both may be necessary.
Psychosurgery: surgical castration and stereotactic neurosurgery are found to be very effective, but are not condoned for ethical reasons.

b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Family Systems, Psychoeducational

c. **Treatment techniques:** Cognitive-behavioral interventions of covert sensitization (identifying the chain of events leading to their pedophiliac acts and pairing these events with potential, negative consequences, olfactory aversion, satiation (training to masturbate to nondeviant sexual fantasies) may help. Also used are: imaginal desensitization, fading, exposure (to erotic adult-adult sexual videotapes or movies), masturbatory conditioning, cognitive restructuring, externalizing cognitive distortions, victim empathy training, prosocial behavior training, psychotherapy focusing on unresolved psychosexual conflicts. Family systems therapy (particularly in cases of incest), focusing on family equilibrium (dysfunctional families may be very resistant to any change brought about by therapy), can be helpful. Sexual addiction treatment, trauma model treatment (treatment to stop the pedophiliac acts and to appreciate the severe consequences of their own molestation), maintenance therapy, surveillance groups, relapse prevention may be part of the approach. Coordinating with other professionals is very important in treatment (Gabbard, 1995, Vol. II).

3. **Transvestic fetishism** - Transvestitism, itself (cross-dressing) does not necessarily constitute a psychiatric disorder.

a. **Medication:** Buspirone, Selective Serotonin Reuptake Inhibitors, Estrogens

b. **Theoretical approaches:** Psychodynamic, Behavioral

c. **Treatment techniques:** "The effectiveness of psychotherapy for either curing transvestitism or alleviating the desire to cross-dress has never been demonstrated" (Gabbard, 1995, Vol. II, p. 1988). Since many of the problems experienced by transvestites are directly related to society's intolerance of transgendered behaviors or gender ambiguity and not of cross-dressing per se (Pomery, 1975), treatment techniques focusing on self-acceptance is a legitimate goal. Decreasing secondary symptoms (e.g.: shame, guilt, depressed mood, suicidality) and addressing issues that might result in adverse social consequences is helpful. Aversion techniques have been found to be powerful, short-term treatments, but may be best used in a multimodal treatment program. Self-regulatory behavioral treatments have been tried. Treatment for the spouses of transvestites may be necessary. They are more likely to seek treatment than the transvestite himself or herself.

4. **Gender Identity Disorder**

   a. **Medication:** Hormonal therapy or surgical reassignment of genitalia may be used.

   b. **Theoretical approaches:** Behavioral, Psychoeducational, Psychodynamic (Interpersonal)

   c. **Treatment techniques:** Treatment may include individual, group, or family therapy or an eclectic combination of all these therapies. Teaching by example, experience, role-playing, reflecting, nurturing, joining with others in a group, re- evaluation, exploration, validation are all helpful. Assisting clients in looking at options for learning to live with who they are, dealing with "gender guilt" or gender transformation if the client has had a surgical reassignment of genitalia are important techniques.

12. Eating Disorders

"People with eating disorders share many psychological and behavioral characteristics with those who have participated in experimentally and naturally occurring starvation . . . i.e.: preoccupation with food, hoarding, binge eating, cognitive changes, mood lability, apathy, irritability, decreased libido, sleep disturbance . . . Awareness of the symptoms that result from starvation accentuates the importance of nutritional rehabilitation in treatment. Improved nutritional status is necessary for successful psychological intervention" (Gabbard, 1995, p. 2089).

A. Anorexia Nervosa

1. **Medication:** No drug or class of drugs has been found to be an effective "anti-anorectic" agent. Comorbid conditions may require medication, however.

2. **Theoretical approaches:** Behavioral, Cognitive, and Eclectic psychotherapy including dietary management are the most effective (Roth & Fonagy, 1996). Other approaches used with some success are Family (especially with younger clients) and Psychodynamic and Group therapies.

3. **Treatment techniques:** Inpatient or partial hospitalization is often needed. Initial sessions may require meeting more frequently than once a week. Normalization of eating is the first priority. Initial sessions focus on developing the therapeutic rapport with the expectation that the client will be required to gain weight. It is important to establish a weight gain contract. Presenting behavioral and cognitive strategies concurrently rather than sequentially is recommended. Early sessions should include cognitive restructuring. The cognitive model of the relationship of thoughts, feelings, and behavior is explained early in the treatment. Modifying irrational attitudes toward eating, weight and self is essential. Other important treatment issues include: techniques to improve body image, self-esteem, social skills training, assertiveness training. Group treatment with a strong leader can be helpful. In general, treatment should include a combination of medical, nutritional, and psychosocial interventions. Psychodynamic therapy can be very valuable for some clients. Medical monitoring and relapse prevention are essential.

B. Bulimia Nervosa

1. **Medication:** Tricyclic antidepressants, MAOIs, Serotonin reuptake inhibitors (i.e., fluoxetine) are useful in reducing binge-eating and purging.

2. **Theoretical approaches:** Cognitive-Behavioral (including dietary management) and Interpersonal psychotherapy are the most successful (Roth & Fonagy, 1996). Psychodynamic, Group, Psychoeducation, and Family therapies are also used.

3. **Treatment techniques:** Optimal treatment includes nutritional counseling, psychotherapy and pharmacotherapy. Early sessions focus on psychoeducation, the normalization of eating, and establishment of therapeutic rapport. Behavioral and cognitive techniques are then emphasized focusing on eating behavior and weight and body shape. Later sessions include non-food-related issues contributing to bulimic symptoms. Eating and weight issues can be addressed when focusing on self-esteem, depression, interpersonal dysfunction, impulse control, stress management and assertiveness. Final sessions focus on consolidation of information and relapse prevention (Gabbard, 1995, Vol. II). Cognitive-Behavioral treatment focuses on modifying behaviors and thinking patterns for more adaptive coping strategies and to eliminate bulimic symptoms. Some clients find psychodynamic therapy an important asset to their treatment. Interpersonal techniques based on therapy for depression with no attention paid to the eating disorder has shown some positive results.

C. Atypical-Eating Disorders

Binge Eating Disorder (the most prevalent of the atypical eating disorders)

1. **Medication:** Serotonin reuptake inhibitors (i.e., fluoxetine) are useful.

2. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic (Interpersonal) may be helpful

3. **Treatment techniques:** Cognitive-behavioral techniques of restructuring, disputing irrational beliefs, cognitive homework, changing distorted thinking can all be helpful (as they are in bulimia nervosa). Interpersonal techniques based on therapy for depression with no attention paid to the eating disorder has been shown to be helpful, as in bulimia nervosa.

13. Sleep Disorders

General treatment principles:
- a good therapeutic alliance
- establish realistic goals and expectations

A. Dyssomnias

1. Primary Insomnia

a. **Medication:** Benzodiazepines, Antidepressants

b. **Theoretical approaches:** Behavioral, Cognitive

c. **Treatment techniques:** Stimulus control and sleep restriction are the most effective single treatment modality. Relaxation methods have also been found to be helpful. Cognitive therapy is used in alleviating emotional distress and in teaching skills for coping with residual sleep disturbances.

2. **Primary Hypersomnia**

a. **Medication:** Stimulants are directed symptomatically at daytime alertness

b. **Theoretical approaches:** No specific psychotherapeutic approach.

c. **Treatment techniques:** Daytime naps may be recommended, but not to disrupt nocturnal sleep. Long naps are generally not refreshing in these clients. Encouraging a regular sleep-wake schedule in clients with this diagnosis is helpful. Clients should have a thorough diagnostic work-up to exclude other disorders such as narcolepsy, breathing-related sleep disorder, and periodic limb movements during sleep.

3. **Narcolepsy**

a. **Medication:** Stimulants

b. **Theoretical approaches:** Group therapy

c. **Treatment techniques:** Three to four short (15-minute) naps per day are useful in conjunction with stimulant medications. These should be scheduled at strategic times (e.g., before driving.) Alertness can improve and the need for stimulant medications can decrease. Very regular sleep-wake schedules are very important. Narcolepsy is a lifelong condition and can cause significant problems. Supportive group therapy can help the client adjust her/his lifestyle to the chronic nature of this disorder. It can also be helpful in learning to cope with the consequences of the sleep problem.

4. **Breathing-Related Sleep Disorder**

a. **Medication:** No medication is recommended for the apnea per se, but may be prescribed for other associated symptoms.

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** General avoidance measures, sleep position training, and weight loss for obese clients can be helpful. Avoidance of sedative-hypnotics and alcohol 4-6 hours before bedtime is recommended. Assisted ventilation is used.

5. **Circadian Rhythm Sleep Disorder**

a. **Medication:** Short-acting benzodiazepine hypnotics are sometimes used.

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Chronotherapy is the only behavioral treatment that has received much research attention. It may be helpful for some clients. A more effective method may involve a strict schedule of an early and regular rising time. Jet lag and shift work sleep rhythm problems may be able to be managed by preventive, environmental and rescheduling measures. It is also important to keep sleep episodes and meals scheduled at regular times. Rotating shifts that move from days to evenings to nights are easier to adapt to than shifts that rotate in a counterclockwise direction. Circadian adaptation may be helped by rapid (every 2- 3 days) or long (about 3 weeks) shift rotations. Appropriately timed, bright white light can be helpful.

B. Parasomnias

1. Nightmare Disorder

a. **Medication:** Not well established in controlled clinical trials. Medications found to have some effect with some clients: benzodiazepines, cyclic antidepressants. Nightmares associated with PTSD may improve with potent REM-suppressing medications (e.g., MAOI's)

b. **Theoretical approaches:** Behavioral

c. **Treatment techniques:** Anxiety reduction i.e., relaxation, exposure-based interventions, i.e., systematic desensitization, rehearsal.

2. Sleep Terror Disorder

a. **Medication:** Benzodiazepines

b. **Theoretical approaches:** Hypnosis, Psychodynamic

c. **Treatment techniques:** Parents of children with sleep terror disorder should be reassured of the normal development of these episodes. The events should be let to run their course, with intervention only to keep the person safe and to prevent sleep deprivation. It is suggested not to arouse the person (child or adult), but to be reassuring, give verbal instructions and physically help them to return to bed. If life stressors or psychiatric symptoms are being experienced by the client, stress management and problem-solving can help. Psychodynamic therapy is sometimes used to gain insight into the stress and help the person change her/his coping strategies. Hypnosis has been used for improved self-control.

3. Sleepwalking Disorder

a. **Medication:** Benzodiazepines

b. **Theoretical approaches:** Hypnosis, Psychodynamic

c. **Treatment techniques:** Since sleep terror and sleepwalking have common features, often occur together and may be part of the same phenomenon, the treatment techniques are similar. One difference is that sleepwalking can be life-threatening, thus it is important to attend to the safety of the person, immediately. The person may need to sleep on the ground floor. Bedroom windows and doors may need to be locked. Removing all potentially dangerous objects, including weapons may need to be done. Rearranging potentially harmful furniture may be important. If sleepwalking is drug induced, the schedule of taking the medication should be changed.

4. **Sleep Disorders Related to Another Mental Disorder**

   a. **Medication:** Medication should be directed to the underlying disorder (i.e., mood disorders)

   b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic

   c. **Treatment techniques:** Techniques used are: elimination of daytime napping, strict enforcement of a regular rising time, reduction of caffeine intake. The combination of pharmacotherapy, behavioral therapy and psychodynamic therapy has been used effectively.

14. Impulse-Control Disorders Not Elsewhere Classified

A. Intermittent Explosive Disorder

1. **Medication:** Medication depends upon the particular impulse-control disorder and consideration of which clients will comply with the pharmacological treatment given. Anticonvulsant drugs may be used, lithium has been effective for violent prisoners who showed impulsive aggression. Beta-blockers have been found to be useful in treatment of temper or in clients with chronic brain syndromes, including mental retardation. One study found the use of buspirone helpful for therapy of impulsive violence in mentally retarded clients (Gabbard, 1995, Vol. II).

2. **Theoretical approaches:** Behavioral, Cognitive-Behavioral, Psychodynamic.

3. **Treatment techniques:** Very little research has been done regarding the treatment of this disorder beyond the use of pharmacological interventions. Many persons with this disorder are often incarcerated, then hospitalized or treated as psychiatric outpatients. Behavioral and cognitive-behavioral programs can help clients learn new, more socially accepted behavior as well as handling stress that may become a crisis. If the behavior is a result of difficulty handling emotional material, psychodynamic therapy can help the client become more aware of anger buildup. These clients may also turn their anger inward and become suicide risks. Since drugs and/or alcohol are often a major part of violence, it may be necessary to treat the client for an addiction.

B. Kleptomania

1. **Medication:** Antidepressants have been useful.

2. **Theoretical approaches:** Behavioral, Psychodynamic, Supportive therapy, Family therapy

3. **Treatment techniques:** Aversive behavior therapy and desensitization have been used with these clients. Psychodynamic and supportive therapy along with antidepressants have been helpful. Stressors (particularly losses and anniversaries) may increase the risk of stealing. Clients may be encouraged not to shop alone. Family therapy may be needed.

C. Pyromania

1. **Medication:** Serotonin uptake inhibitors, Anticonvulsants, Antidepressants

2. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Family

3. **Treatment techniques:** This condition is the most dangerous of the Disorders of Impulse Control. Close follow-up is extremely important. Treatment may be long-term and chronic. Psychodynamic therapy focusing on exploration of a possible traumatic and abusive childhood, cognitive awareness of the consequences of fire setting, awareness of the excitement and arousal preceding the fire setting are important in the treatment. Confrontational techniques may be needed. Substance abuse treatment may be appropriate. Systematic empirical drug trials along with psychotherapy focused on underlying conflicts &/or behavior therapy are used together.

D. Pathological Gambling

1. **Medication:** Clomipramine and a combination of fluoxetine and clomipramine

2. **Theoretical approaches:** Psychodynamic, Behavioral, Cognitive-Behavioral, Rational-Emotive, Reality therapy, Gamblers Anonymous

3. **Treatment techniques:** Psychodynamic therapy is used to understand why the client gambles and to deal with the unbearable feelings that lead to the gambling. Dealing with the underlying anxiety or depression, the excess of time, budget counseling and other reality factors are important. Therapy including the partner can be helpful. Multiple addictions along with comorbid psychopathology and/or personality disturbances may be a part of the presentation. Stress-related physical disorders may need attention. Individual, and group counseling where new behaviors can be learned as well as receiving feedback are recommended.

E. Trichotillomania

1. **Medication:** Antidepressants, particularly Clomipramine

2. **Theoretical approaches:** Behavioral, Psychodynamic, Supportive therapy

3. **Treatment techniques:** Behavioral techniques of habit reversal, i.e., fist-clenching as a substitute for hair pulling, behavior awareness of the hair pulling, identification of the antecedents to the hair pulling, progressive relaxation are used. Behavioral rewards may be given. Behavior therapy in combination with pharmacotherapy may be helpful. Psychodynamic and/or supportive therapy may be necessary in addition to addressing any underlying mood disturbance.

15. Adjustment Disorders

A. **Medication:** Antidepressants - be aware of any more serious mental disorder.

B. **Theoretical Approaches:** Cognitive-Behavioral, Psychodynamic (Interpersonal), Supportive therapy, Psychoeducational, Family therapy, Group therapy

C. **Treatment Techniques:** Analyze the stressors first, to see if they can be changed in any way. Clarify and interpret the stressors for the client. Medical crisis counseling may be necessary. Crisis intervention helps the client put words to the affects and conflicts to reduce the pressure of the stressors and enhance coping. Help the client identify means to reduce the stressors, using and expanding their coping skills. Encourage the client to gain perspective on the problems, to seek out relationships or establish new ones, to attend support groups, self-help groups. Assist the client in management of the stressors. Psychoeducational and cognitive-behavioral therapy can help the client understand the stressors and change inappropriate cognitions.

Axis II

16. Personality Disorders

Although as stated elsewhere in this manual (Diagnosis chapter), personality disorders are long-standing, deeply ingrained, ego-syntonic, and potentially life-long. Gabbard (1995, Vol. II) also notes that these disorders "are not uniformly stable and unchanging". . . . that they "emerge at different ages". . . . and that "the prevalence rates of major disorders, such as borderline, narcissistic, and antisocial personality, vary with age" (p. 2246). He further suggests that "such observations reflect unsuspected variability in the course of these disorders and raises the hope that they can be influenced preventively or correctively through treatment" (p. 2246).

Persons with personality disorders are very challenging clients. Their symptoms often do not appear as serious as some of the clinical disorders, and they may need long-term, extensive treatment because their disorders are so deeply ingrained. Psychodynamic therapy has, in the past, been the treatment of choice with these clients. However, with the recognition of the need for, and value of, more time-limited therapies, the multimodal, and sequential usage of the variety of modalities available should be considered in treatment of clients with personality disorders. In particular, cognitive-behavioral and pharmacotherapies (both focusing on specific problems) may be used during certain phases, especially early in therapy, as part of a longer-term treatment plan. Even though clients with personality disorders may come for treatment and ask for help, they, typically, are very resistant to change. They often have few inner resources and few environmental supports, therefore change can be very frightening. These clients may terminate treatment prematurely.

The overall treatment plan has two levels:

- The therapist must first deal with the presenting (concrete) problem, in order for the client to feel relief and to demonstrate that the therapist can help. The presenting problem may not be a part of the underlying personality disorder. This phase should be active, structured, concrete and behavioral or cognitive-behavioral. Pharmacotherapy may also be used.

- The second level of treatment (after the therapeutic alliance has been established, and the client has made a commitment to work with the therapist for a longer period of time) shifts to a more psychodynamic approach to deal with the underlying personality disorder. Cognitive-behavioral techniques and pharmacotherapy may, at times, be helpful here, also.

A. Cluster A: Odd, eccentric group

(the most resistant to treatment)

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder

1. Paranoid Personality Disorder

a. **Medication:** Medication is often not effective, because of the paranoia. At specific times, limited use of minor tranquilizers for anxiety or a tricyclic or antiserotonergic antidepressants or MAOIs for phobic anxieties or depression might be helpful (Gabbard, 1995, Vol. II).

b. **Theoretical approaches:** Behavioral (for secondary symptoms such as phobic anxiety), Psychodynamic

c. **Treatment techniques:** Care must be taken for the therapist not to become "the enemy". Establishment of a meaningful therapeutic alliance is critical. Respect for the client's autonomy, consistent empathy and tolerance for, and nonjudgemental acceptance of the client's feelings are essential. Attempting to convert the paranoid stance into the underlying depression is needed, then working with the depression. Techniques include empathically eliciting the details of the client's projective system and inner conflicts and self-dislike. Helping the client look at the self-defeating cycles he/she engages in to see how his/her behavior contributes to other people's responses. "Counterprojection" of acknowledging and accepting the client's feelings and perceptions without reinforcing them is also used. Systematic exploration of the client's fears and convictions to develop other explanations and strategies for dealing with people and situations can be helpful. Techniques of confrontation, challenge or reality testing are not helpful with these clients.

2. Schizoid Personality Disorder

a. **Medication:** None recommended

b. **Theoretical approaches:** Psychodynamic, Supportive, Cognitive-Behavioral

c. **Treatment techniques:** These clients may come to therapy only at the urging of others and may drop out of treatment quickly. Psychodynamic therapy is used with clients who are avoidant, rather than indifferent, to human closeness and have a good degree of psychological mindedness (open to self-awareness and working with psychological material). Use of dream analysis, exploring the client's fantasies, and identifying the client's use of splitting and projective identification as defenses have been helpful. Supportive therapy can be very important and may include: sympathetic listening, education about the world, giving advice, problem-solving, and slowly, patiently establishing a relationship with the client. Helping the client be less anxious in social situations by exploring his/her negative assumptions is useful. A "dysfunctional thought record" where typical negative thoughts and assumptions are listed can be used. Giving assignments i.e., around developing a social network and cognitive restructuring i.e., of negative and self-defeating assumptions is helpful. It may be necessary to help these clients find the right job where they can be successful, which is usually one with minimal contact with others. Individual and group therapy are used. Family therapy can be helpful, especially with young clients.

3. Schizotypal Personality Disorder

a. **Medication:** Antianxieties (small doses), Neuroleptics (low doses) with clients with illusions, ideas of reference, and proneness to psychotic ideation (Gabbard, 1995)

b. **Theoretical approaches:** Psychodynamic, Supportive, Cognitive-Behavioral, Reality Therapy

c. **Treatment techniques:** Medication may be used symptomatically. However, some clients do not respond well. Many treatment interventions used with Schizoid Personality disordered clients are also useful with clients with Schizotypal Personality Disorder. Additionally, helping these clients with a better understanding of reality and how their behaviors are not working for them may also be helpful. Suggesting different ways to interact with the world may be needed. Individual, group and family therapy are used with these clients.

B. Cluster B: Dramatic, emotional, erratic, egocentric group

Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder

4. Antisocial Personality Disorder

a. **Medication:** Medication for specific symptoms and behaviors may be prescribed if compliance supervision is maintained. Selection of medication may be predicated on the mode of the client's violence. Specific medications have been shown to inhibit particular modes of violence.

b. **Theoretical approaches:** Clients with this disorder and a concomitant psychopathic disorder respond very poorly to most theoretical approaches to treatment. Nonpsychotic adults with antisocial personality disorder may respond to the following approaches to some degree: Family, Cognitive-Behavioral, Psycho-dynamic. Children with conduct disorder may respond more positively than adults to family therapy.

c. **Treatment techniques:** An assessment must first be made as to whether the treatment setting is secure enough, for both clinician and client, in order to treat a client with this disorder. The therapist may hold both reality-based and countertransference fears of working with these clients. Clients with this disorder who survive into their 40's tend to become less impulsive and less antisocial. If substance abuse is part of the presenting problem, treatment for that disorder is appropriate. These clients often have episodes of depression and suicide risk needs to be assessed. Treatment for depression may be necessary. Clients with antisocial personality disorder have been found to generally respond better to cognitive-behavior therapy treatment if they are motivated to change and are in a milieu or residential setting. Gabbard (1995, Vol. II) quotes an anonymous Australian psychiatrist as saying, when describing treatment for these clients: "Basically it is symptomatic relief, clear guidelines about expected behavior, treatment of any major psychotic illness, realistically accepting them as they are and trying extremely hard not to be too frightened of them" (p. 2290).

5. Borderline Personality Disorder

a. **Medication:** Collaboration with the client regarding assessment for a medication trial is helpful. Medication can be targeted for: cognition (use of low doses of neuroleptics), affect (antidepressants may be warranted), impulse control (medication should be chosen on the basis of their side-effect and potential lethality from overdose), anxiety (somatic - MAOIs or catecholaminergic medications; psychic anxiety - benzodiazepines [but can lead to dependency on the medication]) (Gabbard, 1995, Vol. II).

b. **Theoretical approaches:** Cognitive-Behavioral, Psychodynamic, Supportive

c. **Treatment techniques:** Individual psychotherapy is the norm, while family and group therapy can be very helpful. Being aware of any suicidality is important with these clients. Development of a working relationship with clients with this disorder is a necessity. Cognitive-behavioral therapy first focuses on symptoms of depression and any substance use, then expands to helping the client with his/her sensitivity to rejection, self-destructive and aggressive behavior, depersonalization, and black and white thinking. Techniques include confronting irrational beliefs, modeling, cognitive restructuring. However, usual strategies of cognitive-behavioral therapy need modification including greater flexibility in the therapy and greater attention to the creation and maintenance of the therapeutic relationship. Psychodynamic therapy focusing on increasing insight and providing a corrective emotional experience is often very helpful. Supportive therapy with the focus on reality problems of daily life is often used. Follow-up with clients with this disorder has found that short-term therapy has not been as successful as at least one to two years of treatment and some clients are in treatment for longer periods of time. Time-limited (6-12 months) therapy focuses on specific situational or interactional problems, but because of the lack of transference gratification many borderline clients drop out (Gabbard, 1995, Vol. II). Frances and Ross (1996) note that "Time is on our side in treating Borderline Personality Disorder. A number of studies indicate that the long-term prognosis is surprisingly good because patients seem to mellow out with age" (p. 298).

6. Histrionic Personality Disorder

a. **Medication:** None recommended

b. **Theoretical approaches:** Psychodynamic, Behavioral-Cognitive, Psychoanalysis, Marital, Group

c. **Treatment techniques:** Horowitz (in Gabbard, 1995, Vol. II) describes four phases of formulation and treatment for clients with this disorder. She encourages an integrative approach using psychodynamic and cognitive-behavioral formulations and techniques. She suggests using "psychodynamic approaches for how to establish a therapeutic alliance, understand and handle various motivational levels of transference, and counteract resistances to change. Cognitive-behavioral means can be employed for identifying irrational cognitions, disruptions of clear conscious representation and expression, and techniques that reinforce the repetition of more adaptive actions" (p. 2314). The four phases are identified as: 1) Clarifying symptomatic phenomena and establishing a therapeutic alliance, 2) Identifying and dealing with shifts in state of mind, 3) Identifying and counteracting defensive control processes, 4) Identifying and helping the (client) to modify irrational beliefs and contradictions in schemas of self.

7. Narcissistic Personality Disorder

a. **Medication:** None for the personality disorder, itself. Pharmacotherapy is indicated for treatment of comorbid Axis I conditions, i.e., affective or anxiety disorders.

b. **Theoretical approaches:** Supportive, Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** The goal of therapy needs to be established at the beginning. Is the goal to give support or is change the goal? Brief therapy using psychodynamic and cognitive-behavioral techniques may include: increasing insight, modifying of destructive behavioral patterns, pointing out the client's own role in generating and perpetuating his/her life problems and defining the client's task as not acting impulsively and focusing on trying to see the other person's point of view. Longer term therapy includes a flexible therapeutic attitude toward the client, and balancing empathy and anxiety in the therapy to push the client toward greater self-awareness. Empathic acceptance is greater in the early part of treatment, while interpretive challenging is used more later. It is important to address the client's subtle expressions of devaluation of the therapist in order that the therapy will not be undermined. Addressing the harshness of the client's conscience is important in the therapy. Both couples therapy and group therapy can be helpful, but individual therapy should be taking place concomitantly.

C. Cluster C: Anxious, fearful, indirect group

Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder
Personality Disorder NOS

8. Avoidant Personality Disorder

a. **Medication:** MAOIs and benzodiazepines are used for clients with generalized social phobia and may be helpful with avoidant personality disorder. No other medication is recommended as a primary form of treatment.

b. **Theoretical approaches:** Cognitive-Behavioral, Rational-Emotive, Psychodynamic including Interpersonal

c. **Treatment techniques:** These clients may be very apprehensive when entering therapy, necessitating careful, deliberate beginning treatment. Establishment of a therapeutic alliance is essential. Anxiety management early in therapy is important. The following cognitive-behavioral techniques are used: social skills training, in conjunction with exposure techniques, (either graduated or flooding) which exposes the client to experiences they have been avoiding, systematic desensitization, cognitive restructuring and other cognitive techniques targeting the client's false assumptions about the effects of failure. Psychodynamic and/or interpersonal therapy, either as a primary treatment or as an adjunct to a cognitive-behavioral approach is helpful for many clients. The combination of psychodynamic and cognitive-behavioral therapy may be most useful. Exploring the psychodynamic meaning of their anxiety and the source of their fears (often shame and embarrassment) is important, since these clients often shun personal interactions to avoid self exposure and the expected criticism. Behavioral exercises help desensitize the client and introduces further material for the psychodynamic work. Interpersonal therapy provides these clients with a healing interpersonal experience in the therapeutic relationship. If family treatment is considered, the family should be educated about the importance of behavior changes in the client. Group therapy is generally not helpful.

9. Dependent Personality Disorder

a. **Medication:** Medication may effect some clients with a concurrent Axis I disorder (i.e., depression), but there is little evidence of benefit for the dependent personality disorder, itself.

b. **Theoretical approaches:** Psychodynamic, Cognitive-Behavioral

c. **Treatment techniques:** Developing a trusting relationship and allowing the client to transfer dependent wishes onto the therapist is important when beginning work with these clients. The dependent transference toward the clinician is dealt with in a way to promote emotional growth. Also to be addressed is the use of therapist expectations and support for the client to develop self-expression, assertiveness, decision making and independence (Beck, et al, 1990). The therapist should help the client conceptualize his/her own goals and, if healthy, the therapist should discuss and support them. It is important to discuss the consequences of each client goal and for the therapist to give support to help the client tolerate the anxiety of making choices. The client is then encouraged to commit to progressively more complicated actions related to the choices. In cognitive-behavioral therapy, the client's dependent behavior is accepted at first, but self-reflection, agenda setting and treatment goals are then encouraged. Techniques include: challenging dichotomous thinking, graded in-vivo exposure to anxiety-provoking situations, monitoring of client's automatic thoughts (particularly of inadequacy), challenging the client to select healthier responses, relaxation training, assertiveness training. Group psychotherapy can be helpful in treatment of these clients.

10. Obsessive-Compulsive Personality Disorder

a. **Medication:** There are no medications specifically for this disorder. Nonspecific anxiolytics may be used, but attention must be paid to the possibility of medication dependency. Antidepressants may be useful with clients with significant depressive symptoms.

b. **Theoretical approaches:** Psychodynamic, Cognitive

c. **Treatment techniques:** Individual psychodynamic therapy or psychoanalysis is the treatment of choice, although formal outcome studies have not been carried out. The client's use of defenses (i.e., intellectualization, isolation of affect, undoing, reaction formation, displacement, and regression) must be supportively pointed out and questioned so the client can learn how he/she tries to control the anxiety he/she experiences. Education of the client is important so she/he will understand that the controlling, rigid style prevents satisfying relationships and damages work performance. Addressing the resulting anxiety and projection onto the therapist of expected punishment and retaliation is necessary. Paying attention to the reality distortions the client experiences, allows for understanding of his/her feelings of guilt regarding his/her impulses and his/her need to be punished. As the client becomes more aware that his/her hostile or erotic thoughts and impulses are not the same as actions, and do not necessitate moral censure, he/she will become less anxious, experience less harsh and self-judgmental attitudes, and his/her defenses will become less rigid and exacting. The client's self-expectations will be modified. Intensive group treatment may be useful with these clients. Short-term therapy may be used with clients with obsessive-compulsive personality disorder when they are in the midst of a crisis. Focused goals in helping the client accommodate to change may be used. Gabbard (1995, Vol. II) reported one 16-session therapy study found moderate changes in personality, including a decrease in negative and ambivalent self-references, and an increase in positive self-references. Also some decrease in procrastination and narcissism was found. The therapist may experience countertransference problems which need to be addressed in supervision and/or personal therapy so as not to impede the therapeutic work with these clients.

Major sources for this chapter: Frances & Ross, 1996; Gabbard, 1995; Roth & Fonagy, 1996; Seligman, 1990.

CHAPTER 6

Counseling Theories

PSYCHODYNAMIC PSYCHOTHERAPIES

These theorists believe that the personality is the result of interactions of opposing (instinctual) forces which create conflicts within a person. The task of psychotherapy is to understand these forces, resolve the conflicts and bring the forces into more harmoneous functioning.

1. Psychoanalysis - Sigmund Freud

Psychoanalysis is both a method of therapy and a theory of personality. To understand the goals and techniques of Freud's psychotherapy, one must understand the personality theory behind it (See Personality Theories). Freud developed his hypothesis about the role of the unconscious processes in hysteria and other mental disorders and the benefits of "free association" and "catharsis" while treating women with these disorders (ex: the case of Anna O.).

Psychoanalysts understand maladaptive behavior as a reflection of unresolved, unconscious conflicts that occurred in childhood. The goal of treatment is to change the maladaptive behavior (pathological symptoms) by bringing into consciousness unresolved, unconscious material and integrating it into the total personality structure.

Freud believed the therapist should be a "blank screen" against which the client's unconscious associations (and therefore conflicts) could appear more clearly.

The therapist then uses the following techniques to address the client's material.

- clarification - restating client's statements and feelings
- confrontation - helping clients see behavior in a new way
- interpretation - explicitly connecting present behavior to unconscious processes
- working through - clients assimilating new insights into their personality

Catharsis is important in psychoanalysis. This phenomenon is the emotional release resulting from recall of previously unconscious material. It allows "insight" to happen where the client becomes aware of unconscious conflicts underlying her/his dysfunctional behavior.

2. Neo-Freudians

Neo-Freudians, generally, reject Freud's view of personality as being determined primarily by instinctual forces and instead emphasize the role of social and cultural factors. Many basic techniques of classical psychoanalysis are used to understand the client's social environment.

A. **Karen Horney** was trained in the orthodox psychoanalytic tradition, but early in her career she challenged Freud's ideas on feminine psychology, on the nature of the neurotic process, on the concept of the death instinct, and particularly on the role of cultural factors in neurosis. She formulated a holistic notion of the personality as an individual unit functioning within a social framework and continually interacting with its environment. At the center of her theory was the concept of the self. She believed that an actual self, a real self, and an idealized self were the main facets of the personality. The actual self is the sum total of the individual's experience. The real self is a more central force or principle, unique within each individual and equivalent to a sense of healthy integration or harmonious wholeness. The idealized self is a manifestation of neurosis and serves as a means of avoiding psychic conflict by adopting an attitude of superiority or self-sufficiency or by demanding special consideration. The idealized self is a form of glorified self-image that can progressively encompass more aspects of the personality.

Horney rejected symptom relief or social adjustment as adequate therapeutic goals for therapy. Instead, she emphasized self-realization and self-actualization, dealing with the here and now in contrast to the results of past experience. She felt that the emotional involvement between therapist and patient was an important aspect of the therapeutic process and rejected the stereotype of the analyst as a detached, unfeeling, unresponding mirror.

B. **Harry Stack Sullivan's Interpersonal Psychotherapy** focuses on anxiety and the interpersonal context in which it occurs. Therapy is viewed as a succession of interviews where the therapist is both an active participant in the exploratory process and the observer of trends in the client that the client's defensive patterns prevent him/her from noticing. Personality is viewed as a collection of processes that occur as an outgrowth of interpersonal experiences and not the unfolding of intrapsychic forces.

Sullivan agreed with Freud that personality development involved predetermined sequences of stages. He described each stage as being characterized by different interpersonal factors rather than instinctual ones as Freud did. Sullivan also recognized the role of cognitive experience in personality development. He believed that a person achieved mental health to the extent that she/he became aware of her/his interpersonal relationships.

The primary goal of Interpersonal Psychotherapy is to identify and correct the client's distortions where the client responds to a person as though she/he were a significant person from their past. This is necessary in order for the client to have more realistic and mutually satisfying relationships.

C. **C. G. Jung's Analytical Psychotherapy** "is an attempt to create a dynamic interplay between the conscious and the unconscious through the use of symbolism. Analytical Psychology regards the psyche as a self-regulating system whose functioning is (purposeful) in that it confronts the (person) with an internally imposed direction toward a life of fuller awareness" (Whitmont and Kaufmann, 1973, p. 85). A dialogue is developed with dreams, fantasies and other unconscious material, between the conscious state of the person and his/her personal, as well as the collective, unconscious. Therapy is not seen as a fixed structure, but as a process of self-knowledge, a reconstruction of the personality or even as an education.

The most important principal in Jungian psychotherapy is that the basis of any analysis is experiencing, not merely intellectual understanding. Therapy involves an active interchange between the analyst and the client with the main emphasis on the conscious assimilation of the immediate experience. Interpretation is the main work of the analytic process. Analysis attempts to make conscious, as much as possible, what has been unconscious, making a behavioral change possible.

3. Ego-psychology

Anna Freud
Heinz Hartmann
David Rapaport
Erik Erikson
Otto Kernberg

Ego-psychologists stress the development of a variety of ego functions.

A. Ego-Defensive Functions

Ego-defensive functions develop through the resolution of conflicts. These bear some similarity to Freud's "ego". Anna Freud delineated several ego defenses (regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, displacement, identification with the aggressor) which function as positive coping mechanisms or neurotic defenses depending on the success of the conflict resolution. She also posits a developmental sequence of emergence of the defenses.

B. Ego-Autonomous Functions

Hartmann and his followers propose a more "conflict-free" ego, which includes adaptive and non-conflictual functions such as: perception, intuition, comprehension, thinking, language and learning. Hartmann's theory focuses on the positive adaptations of the ego created outside of instinctual conflicts and the balancing of the internal and external forces required for the optimal functioning of the individual.

Treatment goals and techniques are similar to classical psychoanalysis, but tend to emphasize current problems as opposed to past experiences. The focus is on neurotic as well as non-neurotic parts of a client's personality. There is more emphasis on providing clients opportunities for "re-parenting" rather than emphasizing the transference.

4. Self Psychology

Self Psychology is derived from the work of Hartmann, Erikson and Lichtenstein. The major contemporary theorist is Heinz Kohut, who views the self as a separate narcissistic structure independent of id, ego and superego. The self is seen as either separate from the ego or as a supraordinate integration of the id, ego, and superego. Narcissism is believed to undergo its own separate line of development through several phases toward a mature, cohesive self-organization.

BEHAVIOR THERAPY

(Wolpe, Skinner, Lazarus)

Both Classical Conditioning (Joseph Wolpe) and Operant Conditioning (B. F. Skinner) emphasize current behaviors, reject the premise that maladaptive behavior is symptomatic of underlying psychopathology, and regard maladaptive behavior, itself, as the psychological disorder. In the classical conditioning approach, certain respondent behaviors such as knee jerks and salivation are believed to be elicited from a passive organism. In operant conditioning, operant behavior is seen as action that operates on the environment to produce consequences. The primary goal of treatment is the elimination of maladaptive behavior. The current trend in Behavioral Therapy is toward developing procedures that give control to clients and thus increase their range of freedom. Behavior modification works toward increasing a person's skills in order for that person to have more options for responding. This process is seen to increase rather that to restrict individual freedom. Arnold Lazarus has been a major force in behavior therapy. He worked with Wolpe, but split with him when he thought Wolpe was too rigid and narrow in his outlook.

COGNITIVE-BEHAVIORAL THERAPY

All of the Cognitive-Behavioral therapies emphasize the collaborative relationship between therapist and clients. They believe that psychological problems are mostly a function of disturbances in cognitive processing. They focus on changing cognitions in order to change affect and behavior. These theories are generally time-limited and treatment is psychoeducational and focused on specific and structured target problems.

1. Rational Emotive Therapy (RET) (Albert Ellis)

Albert Ellis' Rational Emotive Therapy (RET) is now known as Rational Emotive Behavior Therapy (REBT). This theory is based on the assumption that people contribute to their own psychological problems and specific symptoms by the way they interpret events and situations in their life. Ellis' approach is known as the A-B-C theory of personality: A is the actual event; B is the person's belief system and C is the consequence. He sees emotional problems as the result of the person's beliefs, which must be challenged. He uses the method of logical and rational thought to apply to irrational beliefs. Cognitive therapy is used to change dysfunctional emotions and behaviors by modifying what is seen as inaccurate and dysfunctional thinking. The techniques used are designed to identify and test the person's misconceptions and faulty assumptions. Ellis believes that a reorganization of one's self-statements results in the reorganization of one's behavior.

2. Cognitive Therapy (Aaron Beck)

Cognitive Therapy focuses on the understanding of emotional problems through the cognitive content of a person's reaction to that problem. The goal of therapy is to change dysfunctional emotions and behaviors by modifying inaccurate and dysfunctional thinking. Clients learn to identify these distorted and dysfunctional cognitions through a process of evaluation. They learn to discriminate between their own thoughts and reality; to be aware of and monitor their thoughts and assumptions, particularly their negative, automatic thoughts. Beck does not believe in the concept of irrational beliefs. He sees beliefs as problematic, but not irrational. Some techniques used are: assertiveness training, behavioral rehearsal, graded task assignments, relaxation methods, shame-attack exercises, thought stopping, cognitive restructuring. Cognitive therapy is particularly used in depression, but is applicable with other diagnoses as well. In recent development of the theory, cognitive therapists are focusing on the client's subjective framework and interpretation as being more important than the objective of distorted beliefs. This "constructivist's" perspective stresses the client's reality rather than the accuracy or rationality of the thought.

3. Social Learning Theory (Albert Bandura)

Bandura combines learning by classical and operant conditioning of the behaviorists, with learning by observation and imitation, using modeling as the technique for learning. An individual or group models or acts as a stimulus for similar thoughts, attitudes, and behaviors of the observers. In observation and modeling, a client can learn to perform particular acts or think in particular ways without trial and error learning. He believes that modeling is paramount in the development and modification of much of human behavior.

Social Learning theory sees three major effects of modeling:

1. learning of new responses or skills and the performance of them
2. inhibition of fear responses
3. facilitation of responses already learned

Types of models used:

1. live models
2. symbolic models (films, videotapes, etc.)
3. multiple models (successful peers, co-leaders, etc.)

HUMANISTIC THERAPIES

1. Gestalt Therapy (Fritz Perls)

Gestalt Therapy, the system of psychotherapy developed by Fritz Perls is an existentially based system that is noninterpretive, nonhistoric and follows the principle that the whole is greater than the sum of its parts. The primary focus is the here-and-now. The process of the therapist-client relationship is of central importance since it is the quality of the relationship that determines what happens in the therapy. The process of interactions, not the content, is the major focus. Gestalt therapy focuses on the immediate present awareness of one's experience. The concepts of transference and countertransference are thought not to apply and cognitive explanations or interpretations of "causes" or "purposes" of behavior are rejected.

2. Person-Centered Therapy (Carl Rogers)

Person-Centered Therapy developed by Carl Rogers posits that human growth is a process of continual development and change. The central hypothesis is that the growthful potential of any individual will tend to be released in a relationship where the helping person is experiencing and communicating realness, caring and deeply sensitive nonjudgemental understanding. Rogers views a person's underlying nature as self-actualizing. The inherent tendency of the organism is to develop all its capacities in ways which serve to maintain and enhance the organism. Growthful change will take place if the therapist exhibits attitudes of congruence, positive regard and empathic understanding toward the client.

REALITY THERAPY (WILLIAM GLASSER)

William Glasser's Reality therapy involves a series of theoretical principles that can be applied to persons with behavioral or emotional problems or anyone seeking to gain a success identity. The focus is on the present and on behavior. The therapist guides the person to see him/herself accurately, to face reality, and to fulfill his/her own needs without harming him/herself or others. The major principle is personal responsibility for one's own behavior which is equated with mental health. Reality therapy is used successfully with adolescents, individually and in groups as well as with adults who are substance abusers. It began in, and continues to be used in, institutional settings, as well as outside these settings.

TRANSACTIONAL ANALYSIS (TA) (ERIC BERNE)

Eric Berne's theory of Transactional Analysis includes the presence of three ego states that are active, dynamic and observable. They are referred to as the Parent, the Child, and the Adult. Each of these states is theorized to exist and operate in any individual. Persons are motivated by a need for strokes (recognition) and will design a life script based upon early childhood beliefs about oneself and others. These existential beliefs are reinforced by a person engaging in repetitive stereotyped games which are considered "unstraight social interactions with others". Psychotherapy techniques are borrowed from a variety of sources: psychodrama, Gestalt therapy and others. TA is customarily conducted in groups of 8 - 10 people.

EXISTENTIAL PSYCHOTHERAPY

In the Existential perspective, a person's self-awareness is considered to be the most basic experience. The uniqueness and individuality of each human being, of each human existence is emphasized. Extential approaches emphasize actual, immediate, usually emotional experience as opposed to historical (developmental) determinants. This is close to the "self-actualizing" emphasis of some other psychological theories. A person is seen to change by existing differently. (There is an emphasis on 'authenticity,' making life and choices one's own.) Anxiety points to avoided possibilities of living. Authentic relating to others is stressed.

Eugene Gendlin's Experiential Psychotherapy is an example of Existential Psychotherapy. In this theory, it is believed that one can change oneself in present living. The person's past does not have to determine how one lives in the present. Experiential psychotherapy uses the theory of "felt concreteness". This is a "felt sense" of the complexities of a situation or a difficulty, not primarily emotion, words, or muscle movements.

Gendlin has developed four basic concepts of experiential psychotherapy: (1) "experiential felt sense" which is sensing the whole situation at a particular moment, including thousands of different aspects of a situation, all of them felt together, (2) "differentiation", the sorting out of the different facets of a felt sense, (3) "carrying forward", the bodily feeling when the right words for a felt sense have a physically felt effect - the body feels just a slight bit better because the words fit the felt sense, (4) "interaction" is a physical (bodily) interaction when we live our interpersonal, intellectual and spiritual situations within our bodies.

Family Therapy

DEFINITION OF FAMILY THERAPY

General Systems Theory and Communication Models

The foundation of family therapy, general systems theory is thought to have come out of the physics model introduced by Ludwig von Bertalanffy in 1945. Von Bertalanffy, a biologist, explored the principles of wholeness and organization and the dynamics of change. General systems theory and communication theory are usually the major concepts used in family therapy theoretical models.

A healthy family is considered to be an open system, and like all systems is subject to entropy. Entropy is the physical phenomena of matter moving towards disorder and disorganization with time. Applying this model to family systems, unless the family brings in new information and other kinds of stimulation from the outside, it suffers from entropy. Consequently, the "more closed off a family system is, the more entropic or disorganized it is likely to become." (Churchman, 1968) An open system receives energy from the environment and interacts with it. Using this new energy, it builds new structures and resists the entropic deterioration that occurs in systems that are closed off to outside stimulus.

Communications theory came out of the work of the "Palo Alto Group" that was made up of family therapy pioneers such as Bateson, Haley, Jackson, Satir, Watzlawick, Weakland, and their colleagues. As a result of their work they came to the conclusion that communication takes place at all times in a variety of ways. There is the overt level of words and a second layer of expression (metacommunication) such as voice intonation and body language which can be incongruous with the spoken word. When the two messages are not "congruent," internal and interpersonal friction occurs which can be experienced as confusion, anxiety or difficulty in the relationship with the other.

THE DEVELOPMENT OF FAMILY THERAPY

Many forces contributed to the shaping of Marriage and Family Therapy. Marriage counseling parallels family therapy and they have enriched one another.

Parents were brought into the treatment of emotionally disturbed children in the late 1930's and early 1940's. This phase is referred to as the child guidance movement. This move was prompted by an attempt to keep parents from interfering with the disturbed child's treatment.

Psychoanalytic theories and techniques dominated treatment methodologies in the early 1950's. Psychoanalysts began to notice that clients often had difficulty making personal change or maintaining it when they returned to the family environment. When families were brought into treatment there appeared to be change in the family dynamic and concurrent change in the individual that could not be linked to the individuals therapeutic work.

At the same time, the need for rapid psychological treatment for WW II victims, and the need for more clinicians than were available, pushed a move to alternative treatment modalities.

Family research done by the Palo Alto Group into schizophrenia and family communication patterns pointed to the possibility that the identified schizophrenic was involved in a "dysfunctional family system." They identified a "double bind" communication pattern in the family system which appeared to create an interactive neurosis. Over time this neurotic communication seemed to support the diagnostic identification of a schizophrenic family member.

OBJECTIVES OF FAMILY THERAPY

1. Short Term

Resolve any family crisis that has arisen.

Address problematic behavior of specific family members.

Reduce family stress or tension.

Clarify the problem.

2. Moderate Term

Bring the awareness to the family that they are a system.

Strengthen the marriage or executive system.

Clarify subsystem boundaries (i.e., Parents = Executive system; Children = Subsystem).

Deal with significant biosocial issues of family life, as in defining male and female and old and young roles.

Facilitate congruent communication of thoughts and feelings.

3. Long Term

Establish the boundaries of the family and their "world of experience."

Establish patterns of separateness and connectedness.

Restructure the family so the family system works toward planned change.

Establish cooperative problem solving.

Strengthen the entire family as a system.

Resolution of marital transference.

MAJOR CONTRIBUTORS TO FAMILY THERAPY

1. Nathan Ackerman

Author of *The Psychodynamics of Family Life* (1958) and *Treating the Troubled Family* (1966) is often called the grandfather of family therapy. Ackerman, a psychoanalyst, was the first to point out that successes in individual psychoanalysis were often destroyed when the patient returned to the family system. Ackerman's key concept was the social role and breakdown of role complementarity as an intervention. He advocated the breaking of family rules that maintain rigid patterns and negotiating new rules for more flexible interaction.

2. Gregory Bateson

One of the original members of the "Palo Alto Group," Bateson was an anthropologist and philosopher. He was interested in general systems theory. He identified the "meta-message" in communication and how the non-verbal information could be in direct contradiction with the verbal message.

3. John Bell

Author of the *Public Health Monograph* of 1960 and a founding father of marriage and family therapy. Bell used directive and structural techniques in the treatment of families with acting out or symptomatic children. His parental work included three phases - Parent-Centered Phase - Child-Centered Phase - Parent Child Interaction Phase.

4. Murray Bowen

Started as a psychiatrist specializing in psychotic children. Bowen partnered with Lyman Wynne at the National Institute for Mental Health (NIMH) on a research project focusing on schizophrenic families. Bowen coined terms such as, family ego mass, family projection process, and triangles. Bowen identified a differentiation scale, zero to one hundred which measured relative levels of emotionality and rationality. At 0, the person cannot separate thoughts from feelings and is completely at the mercy of their emotions. The perfect person would be completely free to respond, not react to feelings, establishing their own beliefs and goals on a rational basis.

5. James Framo

Works with couples, groups and families of origin. He sees each partner alone with their family of origin near the end of therapy to integrate intergenerational issues. Framo focuses on transferences that are made on to the partner and the therapist.

6. Jay Haley

One of the original members of the "Palo Alto Group" and author of *Strategies of Psychotherapy* (1963) and the *Power Tactics of Jesus Christ* (1969). Haley's background was in communications theory. Haley believed that relationships were based on a power struggle with each player struggling to define or redefine the relationship to fit their own needs. Haley focused on producing change in behavior through modeling new ways of relating. He pointed out metacommunications and ways to force the system to change using paradox, ambiguous directives, relabeling, and prescribing symptoms.

7. Don Jackson

One of the founding members of the "Palo Alto Group" and author of *Mirages of Marriage* (1968). Jackson was one of the first to apply systems thinking to family therapy. He identified (working with the Palo Alto Group) the "double bind" communication model which was thought to create schizophrenic children in families. Jackson's style focuses on not asking the abstract "why" but observing the current interactive "how."

8. Salvador Minuchin

Used an approach referred to as "structural family therapy." He wrote about his approach in *Families and Family Therapy* (1974). Minuchin's approach relied heavily on a technique called "coupling." He believed that this coupling or joining with the family led to the formation of a "therapeutic system." As the therapist became accepted by the family system he could then educate and model healthy behavior from within the system. He believed the healthier new behaviors would be accepted and adapted because the family believed in his genuine care for them. Minuchin developed the concepts of individual, spousal parental and sibling subsystems; subsystem boundaries; enmeshed boundaries; and rigid boundaries that prevent communication between subsystems. Minuchin's therapeutic goals were to make the family system healthier and more adaptive in their response to one another, family issues and problems.

9. Virginia Satir

Made communication and family systems theory popular for the general public. Author of *Conjoint Family Therapy* (1967), Peoplemaking (1972) and *New Peoplemaking* (1996). Satir is known more as a practitioner than a theoretician. Satir believes that self esteem is a basic drive in all people, and that low self esteem breeds faulty communication. She identifies "family pain" and describes five styles of communication and four types of family games.

A. Communication Styles

The first four styles are dysfunctional and the last one is the only functional style:

- **Placater** - the words agree, the body placates and the insides feel worthless
- **Blamer** - the words disagree, the body blames, and insides feel lonely
- **Computer** - the words are ultra-reasonable, the body is calm cool and collected and the inside feels vulnerable
- **Distracter** - the words are irrelevant, the body is off somewhere else, and the insides believe "nobody cares and there is no place for me."
- **Leveler** - in this model all pieces of the message go in the same direction and are congruent. The words match the body language. There are no or minimal threats to self esteem.

B. Family Games

- **Rescue games** - One member blames, the other placates, while another tries to distract the others from the distress of the interaction.
- **Coalition games** - two people join and agree while one family member disagrees with either one or both.
- **Lethal games** - everybody placates and agrees with others at the expense of their own needs.
- **Growth games** - each person includes self and increases self esteem while interacting with others.

10. Watzlawick

An Austrian and early member of the "Palo Alto Group" he focused on family communication. He used a brief treatment model with the goal being to reduce the client's pain through changing their behavior or the way they viewed their problems. Goals were identified in small, objective, obtainable steps so the client could begin to see progress in the problem solving process. The treatment plan usually consisted of:

A. Obtaining an objective definition of the problem and the behavior that supports it.

B. Devising a plan to create the solution.

C. Implementing the plan, revising as needed.

D. Terminating the case.

11. Carl Whitaker

One of the more irreverent founding fathers, he often risked the conventions of traditional psychotherapy. He has been identified as "driving families sane" by seeming to be more "mad" than they. His work with a co-therapist came out of a stressful setting at the pre-atom bomb Oak Ridge Hospital. Whitaker saw his role as a coach or surrogate grandparent. He began working with a family in a directive, structural manner and moved to a symbiotic relationship with them. He payed attention to unconscious processes and the transference phenomena. He insisted on the use of co-therapists to maintain perspective and objectivity. Whitaker's work is described in *The Family Crucible* (1977) written by his frequent co-therapist Augustus Napier.

12. Lyman Wynne

Focused on personality as being a subsystem of the larger family system. He worked with schizophrenia families at the NIMH. Wynne focused on the task of balancing identity needs with the need to be close. Wynne coined the term "pseudomutuality" to describe one rigid style of role relationship "a predominant absorption in fitting together at the expense of the differentiation of the identities of the persons in the relationship." He also used the term "pseudohostility" to describe a split or alienation which remains at a superficial level (like constantly criticizing Dad's cooking.)

13. Gerald Zuk

Calls his therapy a "triadic-based approach" and focuses on coalitions, alliances and the mediation processes. He is interested in the here and now process of the family. His goal is to break up pathogenic relating such as scapegoating, blaming, and labeling family member's behaviors.

SIMILARITIES AMONG FAMILY THERAPIES

What family therapists all have in common is their focus on the family as a system that impacts the mental health of it's individual members.

- They focus on strengthening the marriage relationship.
- As a rule family therapists tend to place more emphasis on changing patterns of interaction than on increasing understanding.
- They seek to help the family see itself as a system. They avoid identifying a single family member as a patient separate from the involvement of the family.
- They try to help the family establish a healthier "homeostasis" or balance including new levels of individual autonomy.

TYPES OF FAMILY THERAPISTS

1. Conductors

Conductors are active and directive in family sessions. They seek to create family member interaction by establishing a "star-shaped verbal communication pattern with themselves at the center." The therapist seeks to disrupt old dysfunctional communication patterns by forcing most of the messages through themselves. Their healthy modeling is made up of clear, open, unambiguous messages. Examples of conductors are:
Ackerman
Minuchin
Satir

2. Reactors

Reactors are less directive and focus on reacting to whatever the family presents.

A reactor subgroup called "analysts" use analytic concepts and often work as co-therapists. They observe their partner as they become enmeshed in the family system. Afterwards they analyze what it was like to be a part of the family and what it looked like to the observer. Examples are:
Whitaker
Wynne

3. System Purists

System purists focus on the changing communication patterns within families. They usually express less regard for their families change and growth. These clinicians and are more likely to use paradoxical prescriptions and premeditated interventions with the intention of forcing change by unbalancing the family homeostatic system. Examples are:
Haley
Jackson
Zuk

4. Coaches

Bowen's characterization of the family therapist's role. As a coach, the therapist supports the client in their movement toward greater health and individuation.
Bowen

MAJOR FAMILY THERAPY CONCEPTS

- The Family Life Cycle
- Family Secrets
- Family Mythologies
- Roles, Rules and Rituals
- Marital Transference

INDICATIONS FOR FAMILY THERAPY

A. The Presenting Problem is:

- Marital conflict
- Sibling conflict
- Intergenerational conflict
- Family violence

B. Any Individual Problem that affects other family members such as:

- Grief and loss
- Delinquency
- Teen pregnancy
- Chronic illness
- Substance abuse

C. Individual Therapy in which the individual does not seem to be making progress

D. Delinquency and Criminality

E. Problems with School Age Children

F. Severe Marital Discord and Impending Divorce

G. One Parent Families

H. Step Families

I. Schizophrenia

Common themes of schizophrenics in their families are:

1. The parents of schizophrenics are seen as immature, anxious and conflicted. They tend to use primitive mechanisms of defense.
   - Marital relationships are unsatisfactory
   - Family roles are rigid
   - Ways of meeting each others needs are disturbed
   - There is chronic family disequilibrium
2. The schizophrenic child is typically weak, sick, or in need of special care to begin with.
3. The process is transactional in nature. In other words, the schizophrenic is not an innocent victim but rather engaged in a reciprocal process in which each is both acting and being acted upon by others.
4. Outcomes of Family Therapy

   More general family implications are:

   - Improvement in one member of a dysfunctional family leads to disruption of the equilibrium of another and is resisted by the entire family unit.
   - Treatment of an individual needs to be extended beyond the identified patient.
   - Pathology in interaction can only be discovered by observing interaction directly. Transactions cannot be reconstructed on the basis of the individual dynamics of the several family members.

   The nature of the schizophrenic's family system is a result of the relationship each had with their parents. This leads to a three-generation model of schizophrenia and may apply to other syndromes as well.

CONTRAINDICATIONS

A. **Key family members** are not available via any contact media i.e., video conferencing or telephone.

B. **Any family member** is so disturbed the sessions end up focusing on their specific needs.

C. **The family structure or marital relationship** is so fragile that a direct focus would destabilize the dyad.

WHO IS SEEN

The family can be seen as a unit or any subset of that which includes individual members. The theory underlying this flexibility is that if any member of the family changes, they will impact and change the entire family system. Multiple families can be also be seen at one time.

FAMILY ASSESSMENT

A. **The family structure,** it's preferred transactional patterns and the alternatives available.

B. **The family system's flexibility** and its capacity for elaboration and restructuring as revealed by the reshuffling of the system's alliances, coalitions, and subsystems in response to changing circumstances.

C. **The systems resonance,** its sensitivity to the individual members' actions. The system ranges from enmeshment or extreme sensitivity to individual members input, to disengagement or extremely low sensitivity to individual members' input.

See assessments used in family therapy in the chapter on Assessment.

TECHNIQUES IN FAMILY THERAPY

1. Videotape and audio tape

Are used to assist the therapist and the client to see the non-verbal communication in the family. They help the family gain distance and see the patterns of communication in the system.

2. Family tasks

Focus on behavioral change and prescribe exercises for the family to practice at home or in the clinician's office. The tasks are designed to break up dysfunctional coalitions and increase healthy interactions.

3. Family meetings

Are helpful both as a diagnostic tool and an arena in which the family can practice new roles and communication skills. The executive system (parent/s) run the meeting and each family member has an opportunity to be listened to. Problem resolution and family planning are key foci of these recurring events.

4. Psychodrama

Helps increase the family members understanding and empathy for each others situation and feelings.

5. Geneograms

A geneogram is a multigenerational visual picture of a family tree which characterizes information about the relationships between family members as people, for example:

- Loving
- Difficult
- Angry
- Blocked

Other information can be included such as:

- Alcoholism
- Depression
- Other mental health syndromes
- Deaths
- Family violence or abuse
- Marriages
- Divorces
- Family secrets
- Family myths
- Communication styles
- or any piece of information that helps the client, or family understand what he/she has inherited from his/her family of origin.

6. Prescribing symptoms

The therapist predicts a family member's behavior creating the usual response to "reverse psychology" techniques. The symptoms then lose their autonomy and power.

7. Gestalt family therapy

Helps family members see problems in the context of the family system. Techniques include role-playing and family sculpting with the therapist taking a directive role.

8. Using multiple therapists

Using multiple therapists or co-therapists, working behind a one way mirror.

9. Non-Verbal Communication

There appears to be an inverse relationship between verbal and non-verbal expressions. Non-verbal expressions tend to occur in inverse proportion to verbal expressions that are ineffective, or fail to express true feelings. Family members who suppress their opinions tend to give vent to more non-verbal forms of expression than do family members who express themselves more fully in words.

Non-verbal expressions may give clues to attitudes or traits that are directly contradictory to expressed verbal opinions. If the therapist is guided solely by verbalized responses, they may often miss the crux of what is occurring in therapy.

The non-verbal expressions tend to act as hidden cues whereby the total family is prompted continually to re-enact miniature episodes of shared emotional conflict. This re-enactment of crucial role conflicts may have a cathartic effect and seem oriented toward the discharge of accumulated tension. However, its perseverative quality reveals a helpless, repetitive aspect that requires therapeutic intervention.

The therapist elicits suppressed opinions and attitudes of family members by direct challenge and confrontation of preconscious material. In addition, the therapist may pay particular attention to non-verbal expressions by calling attention to them and being able to reach and formulate some central aspects of the family conflict.

PHASES OF FAMILY THERAPY

1. **The engagement period** - lasts roughly the first four or five interviews. This is when the first critical issues occur between therapist and family.

2. **Working phase** - issues are worked out using the therapist's favored style.

3. **Termination** - occurs when therapist or family jointly or unilaterally decide that a satisfactory goal has been achieved, or a referral is made.

THE HEALTHY FAMILY CAN:

- Complete communication transactions
- Interpret hostility
- Consider how others see them
- Discuss hopes, fears and expectations
- Disagree
- Make choices
- Learn through experience
- Give clear messages that are congruent in their behavior
- Have a minimum of hidden messages
- Use "I" messages
- Allow members to be individuals
- Use direct communication (Gurman & Kniskern, 1990)

KEY CONCEPTS

1. **Accommodation** - focuses on the therapist's adjustments to the family dynamics in the service of "joining" with the family.
2. **Calibration** - a regulation of the system or family "thermostat." When the "comfort range" in a family is exceeded, the system attempts to recalibrate and return to its comfort zone.
3. **Conjoint Family Therapy** - coined by Jackson (1959), refers to joint interviews of members of the family with the identified patient.
4. **Detriangulation** - a rigid triad involving two parents and a child in which the parents allow any "deviant" behavior of the child to affect (distract or charge) conflicts they may be having.
5. **Diagnosis** - a working hypothesis of family system interactions as well as the diagnostic impressions of the individuals.
6. **Double Bind** - the dynamics of this communication pattern require two or more family members. It is usually a repeated message that creates a situation in which a family member has no behavioral option that does not end in a negative outcome. The message implies "if you do this you will be punished" and "if you do not do this you will be punished." There is no escape from punishment. The message may include a verbal command layered with a non-verbal actions, such as asking for affection and pushing the child away when they reach out. The receiver is not allowed to comment on the conflictual situation but must remain in the relationship in a double-bind state. Eventually the individual will internally replicate the double bind phenomena in non double bind situations.
7. **Emotional Divorce** - When both partners are emotionally immature and not able to be in relationship, one takes on the role of maturational adequacy while the other acts immaturely. The one who appears to be mature denies their own immaturity and functions the role of the mature one. They act together, yet are not in mature relationship together, thus an emotional divorce takes place. On the surface they may appear to be a happy couple but their experience is that they are alone.
8. **Equifinality** - "the same results springing from different causes." The final outcome of different stimulus resulting in the same event. An estranged couple may come together as the result of a child needing care due to an accident or an emotional attack from an in-law.
9. **Experiential Family Therapy** - the here and now experience, or "gestalt," of a family therapy session.
10. **Family Group Therapy** - joint interviews with several families present at the same time.
11. **Family Projection Process** - occurs when denied aspects of parents are projected onto the children. The children then become the holders of the family pain. Projection can be related to birth order. For example, if the mother was the first child, she may focus her pain on her first child.
12. **Homeostasis** - "the tendency for any system to react toward the restoration of the status quo" in response to any change.
13. **Joining** - the actions and reactions of the family therapist that are targeted to relating with family members or the family system as a whole.
14. **Maintenance** - the technique of providing support of the current family structure or dynamics.
15. **Martial Schism** - relationships in which there is a state of severe chronic discord and disequilibrium between the parents. Communication centers around power struggles, resistance, and the efforts to conceal or avoid facing the deep schism between the marriage partners or executive system. Having little to gain from each other, the parents seek support from the child. Since they are in competition for the child's loyalty, each attempts to diminish the worth of the other child. Schizophrenic females are believed to come from these systems.
16. **Martial Skew** - the relationship is skewed toward meeting the needs of one member of the executive system at the expense of the needs of others. Schizophrenic males are believed to come from these systems.
17. **Marriage Contract** - the known and unknown (withheld and unconscious) understandings each partner has about the marriage relationship.

18. **Mimesis** - accommodating to a family's style and emotional range mimicking their behaviors.
19. **Negative Feedback** - behaviors that restore the comfort zone in a family, i.e., a parents disapproving glance (the look) to an acting child.
20. **Non-Summativity** - "the whole is equal to more than the sum of its parts." When family is analyzed, there is more to look at than the individual members. There is the family entire family dynamic.
21. **Positive Feedback** - actions that upset the existing homeostatic balance to a family and forces the family system to a new, healthier state of equilibrium. The family may experience a new sense of community in a family therapy session and seek to replicate the behaviors that they believe created the experience in their family meetings.
22. **Tracking** - an accommodation technique in which the therapist follows the content of the family's communications and behavior and encourages them to continue.
23. **Undifferentiated Family Ego Mass** - Bowen refers to the "conglomerate of emotional oneness" that exists at various levels of affective intensity within the family. He believed it moved around within the family members and is seen in clearly defined and replicated patterns of emotional responses to stimuli. For Bowen, these responses are definitely different from the individual's autonomous response to a stimuli.
24. **Wholeness** - each part of the system, or family member, is related to the whole family. Individuals are impacted by the activities of each family member. A change in one person creates change in the other members of the family system, or the "whole."

Group Therapy

HISTORY

Group therapy has been around since humans first gathered around the fire and shared their innermost thoughts and feelings. It was seen in the Greek dramas historically and today when a number of people gather over a common theme. Groups serve the need for humans to be social and have a sense of belongingness. Clinically the origin points to a Boston physician Joseph Hersey Pratt. Pratt worked with tubercular patients in groups in 1907 and found that the group experience seemed to strengthen them to face their problems (Mullen, 1962). The use of group therapy increased after World War I and again after World War II when many soldiers, returning home with mental health needs, found limited resources. Groups were formed to serve them, not necessarily because it seemed to be the best approach. But here again, counselors found that talking about their experiences in groups appeared to help the soldiers face the problems they were dealing with after their traumatic experiences. In Europe Alfred Adler formed "therapeutic communities," and Trigant Burrow, a student of Freud, observed group behavior in camp retreats. In the 1930's Paul Schilder of New York identified the transference process of group members onto their group leader. Jacob Moreno began working with groups in 1907 but did not coin the term "group psychotherapy" or "psychodrama" until the 1930s. One of the more recent popular group styles was the "encounter group" of George Bach. These groups met nonstop for 20 hours or more. The rationale was that the constant stimuli broke down the defenses and facilitated honest communication and personal insight. Today there are many types of groups that are treatment alternatives for clinicians.

ADVANTAGES OF GROUP THERAPY

- Social learning
- Social support
- Safe place in which to try out new behaviors
- Safe environment in which to confront others
- Social arena in which to try out new roles
- Sense of belongingness
- Safe place in which to practice new social skills and styles
- Spreads out the counselor's expertise in schools and agencies
- Lower cost of therapy per individual

TYPES OF GROUPS

The general goals of group therapy for a client are: trying out new social and relational skills, developing a responsibility for others and increasing self-awareness. More specifically identified groups present more specific goals. Many theoreticians have created groups based on their theoretical models dynamics. The following is a list of the more well known group formats. There are many more.

1. Activity Groups

These groups are helpful for both adults and children. The members jointly select an activity and learn about the decision making and negotiating process as they engage in the activity.

2. Client-Centered Group - Carl Rogers

Goal	Wholeness and self-actualization.
Process	Increasing self understanding and the alteration of self concept.
Focus	Insight and affect oriented.
Leader	Group member centered and process oriented.

3. Confrontational Groups

This kind of group is often used on locked psychiatric units. Group members are confronted with their aberrant behavior in a direct, clear manner. Since the client does not stray outside the therapeutic community, support systems are in place to deal with reactions to the confrontation.

4. Discussion Groups

Group members discuss issues in the presence of a leader mostly on a cognitive basis, but with some emotions emerging. Examples are schools, camps, training programs and any facilitated discussion group.

5. Eating Disorder Groups

There are many different types of eating disorders and settings in which eating disorder groups meet. Screening for medical problems and Axis II diagnosis is important. The goals of the group influence the screening criteria. The three main types of groups are (1) psychoeducational (2) inpatient and (3) outpatient which requires high motivation and interactional skills.

6. Encounter Groups

The primary emphasis of the group is on individual expression and recognition of affect. Carl Rogers used this term in the 1960's to describe a humanistic and growth oriented approach.

7. Existential Group Therapy

Patients are confronted directly about their dysfunctional behavior. Transference and the therapist's countertransference are examined.

8. Functional/Industrial Groups

These groups are usually task directed. The group is composed of work units or departments and may include both management and line staff. Ad Hoc groups are usually formed temporarily for a strategic purpose.

9. Gestalt Groups - Fritz Perls

Goal	Awareness of the here and now, personality change and finishing unfinished business.
Process	Articulating the experience of the here and now, working with the group leader in the "hot seat" to bring personal issues to the forefront, sometimes involving personal catharsis.
Focus	Action/insight and emotions.
Leaders role	Group member centered when leader is not working with someone in the hot seat, process oriented.

10. Marathon Group

An extended one session group, 20 hours or more.

11. Psychodrama Group

Originated by Jacob Moreno, psychodrama incorporates role playing, makeup, interpersonal relationships, conflicts and emotional issues into Moreno's model. A dramatization includes the protagonist or patient who acts out the problems; alternate egos, people who enact different aspects of the patient; the audience and the director, or therapist, who guides the players towards new insights. The goal of the psychodrama is to bring awareness and reframe the individuals' perceptions of the event/s. Being immersed in the event allows for catharsis, insight and reality testing.

12. Psychodynamically Oriented Group

Therapists who offer psychoanalytically oriented group psychotherapies do not suppose that the outcomes will be identical with those of classical analysis but assume that the interactions between the members of the group, when focused on, will provide the kinds of insights that take place in individual work.

Goal - to restructure the client's character and personality.

13. Process Oriented Group

Process oriented groups recreate, analyze, discussing and interpreting while working through personal and interpersonal issues.

Focus	Insight and affect oriented.
Leader	Leader centered and process oriented.

14. Rational-Emotive Group - Albert Ellis

Goal	To create constructive changes in the client's thinking and behavior leading to greater acceptance of self.
Process	Learning the ABC theory of (A) practicing, (B) disputing and (C) exercising, self discipline while addressing irrational beliefs and values.
Focus	Is on action/insight and rational oriented behavior.
Leader role	Leader centered and both process and outcome oriented. Therapist is viewed as a teacher rather than a therapist whose task is to help eliminate self-defeating behaviors.

15. Self Help Group

Self help members usually have a common problem and come together to "get better" with the support of others. There is more of a focus on personal responsibility and active working on problems than is done in support groups.

16. Support Group

Groups like Alcoholics Anonymous (AA) support the idea that the individual has potential goodness and will achieve resolution of his/her problems when working with and being supported by people with the same issues.

17. T Groups

T Groups or training groups grew out of the field concepts of Kurt Lewin in the 1930's and 1940's. His work became the basis of the Tavistock Small Study Groups in Britain. The focus of this group is to examine and improve interpersonal skills. How one functions within a work site group is examined.

18. TA Groups - Transactional Analysis - Erik Berne

Goal	Awareness, making new decisions and altering the course of life.
Process	Interacting with others and identifying the role you play in these interactions based on the TA model of Parent, Adult and Child ego states.
Focus	A combination of insight/action and rational affect oriented.
Leader	Leader centered with equal process and outcome orientation.

19. Therapeutic Community

A therapeutic community is one which is sensitized to the feelings and needs of the patients. This community can be made up of lay people or professionals, or a blend of the two.

GROUP STRUCTURE

1. Size of group

A. Treatment Groups

Many experienced group therapists recommend seven to nine members. This allows for a wide range of diversity in the make up of the group and allows for enough time for group members to experiment with a new range of defenses, emotions and new interaction skills.

B. Discussion groups, supportive groups, activity groups and social groups permit a larger membership.

C. Marathon groups often contained more than 20 members.

D. A therapeutic community includes every member of the community.

2. Types of group members

All groups should share the same agenda and group expectations. In general, heterogeneous groups are the preferred working model.

A. Heterogeneous

These groups offer more variety and creative ways of looking at problems. Mixed groups are usually the most effective, but occasionally a group member is so different that he/she skews the group into dealing with his/her differences rather than the agenda the group came to work with.

B. Homogeneous

Homogeneous groups can be effective for problem solving. People with similar backgrounds or current life phases or situations can validate one another's experiences and identify common problems more quickly than a mixed group.

3. Closed versus Open Groups

Closed groups do not allow new members. This does deprive the members from dealing with the process of integrating a new member to the group family. However, with open groups, if the member policy is too open-door, new people will arrive and leave too quickly for cohesion to develop and the group process will not proceed in a helpful way.

4. Group Communication Structures or Sociograms

Group Communication Structures or Sociograms are used to identify or map group member's interactions and choices about interpersonal relations within the group.

5. Frequency of sessions

Most groups meet weekly to maintain continuity and focus of group members. Marathon groups often meet only once and discussion groups need only meet when the issues demand.

6. Screening Group Members

Each member needs to be screened before he/she enters the group to ensure an appropriate fit. Some of the areas that a screening should focus on are:

- History of the family of origin
- Medical history
- Diagnostic history and a sense of where the client stands on the continuum of the illness and wellness in relation to their particular diagnosis
- Level of psychological education
- Ability to set personal boundaries
- Ego strengths and defense mechanisms

GROUP MEMBERS RIGHTS

Informed consent - the client is told before the group about his/her rights and expectations of group members. Members must receive this information individually before group counseling begins so each one can make an informed decision to join or not to join. If the client is not given this information until he/she is a part of the group, and then does not want to abide by the guidelines, he/she will find it difficult to exit the group, which is more difficult than breaking contract with the therapist. Ideally, this information is in writing and is signed by the new group member. A copy is kept by the group leader and a copy is given to the group member.

Rights included in the informed consent must include but are not limited to:

- Confidentiality
- Freedom From Undue Pressure
- Participation Is Voluntary (If It Is)
- Freedom Of Exit (If There Is Not A Commitment Requested)

GROUP STAGES

There are different descriptions of the group stages by theorists. They all seem to have similar process, starting with the beginning phase of checking other members and the leader out and finding their place, the middle or working phase, and the final or termination phase. Different stage models follow:

1. Coreys Stages

A. Orientation and Exploration

The issues are inclusion, identity and trust. The leader provides his/her expectations about honesty and spontaneity.

B. Transition

The issues are anxiety, conflict, resistance. The leader may be challenged by members. The leader's task is to create an environment that is supportive while dealing with member anxiety and trust issues.

C. Working

The issues are cohesion and working as a group. The group can now depend less on the leader. Group members self-explore more on their own. The leader's tasks are to maintain support, model healthy behavior, and help members translate insight into action or behavior change.

D. Consolidation and Termination

The issues around ending and loss are now on the table including feelings about leaving, unfinished business and preparing to take what they have learned in the group outside. The leader must deal with emotions, support change and help members move into their individual futures.

2. Rogers Stages The Transition Process Of Groups From Orientation To The Working Stage

- First - Milling around.
- Second - Resistance to personal expression. The group leader needs to take charge and give some direction and/or modeling.
- Third - Beginning to express feelings. Often this begins with past feelings. The group leader can help members stay present and express current feelings.
- Fourth - Express current negative feelings.
- Fifth - Daring to take risk and explore present feelings as the members get to know one another better.
- Sixth- Periods of silence begin to occur which the group leader must manage and decide when to allow them and when to intervene.
- Seventh - Spontaneous responses to feelings and behaviors, both positive and negative.
- Eighth - Members begin to accept themselves and think about what they like and do not like and want to change.
- Ninth - Members begin to accept confrontations as helpful feedback rather than perceiving them as attacks.
- Tenth - A closeness is developed by the group.
- Eleventh - Behavioral changes occur in group members.

3. A Model For Psychodynamically Oriented Groups

A. Beginning Phase

The client's prime conflicts, transference feelings, emotions and concerns from the past often arise around the issue of inclusion. Each member wants to know at some level whether he/she will be accepted by the leader and the group, where he/she stands in relation to popularity and to what degree others will show tolerance or aggression.

B. The First Meeting

A counselor can begin with as few as four or five patients and add other members gradually if it fits the group model the counselor is using. The first meeting is a good time to tell everyone about the group rules concerning arrival, confidentiality, breaks, letting the group leader know if they will miss a session and any other rules the group leader believes are important. It is important that all members hear these rules together so everyone knows everyone else was told the same information. On the other hand psychoanalytically oriented practitioners sometimes are interested in increasing anxiety at the start of the group by not sharing any information and observing the group member's defensive structure.

C. Middle Phase

Transition stage - dealing with resistance. The main issue here is often power struggles with the main questions being: Can I exert or maintain control? Can I challenge the authority of the leader? This phase resembles the enmeshment of infancy and individuation of the adolescent. Often times the group leader observes negativity or rebellion in group members.

D. Later Phase

The group matures and parallels successful separation and individuation. Group members model healthy interdependency and respect each other's separateness while sharing intimacy.

E. Termination

- Appropriate - leaving a group or having the group end is a good time to deal with themes of loss and letting go. The counselor can orchestrate the group experience by bringing up the issue of termination and addressing the feelings of sadness and loss of the support of the group. Several meetings are needed to deal with the issues that arise.

- Premature - often occurs because the client cannot master his/her anxiety or other issues and choses to leave (flight) rather than deal with the issues. It is up to the group leader to decide what to do about this event about the person who has left, and of course to deal with the feelings of the group members who remain.

4. The Five Stage Model

- Forming
- Storming
- Norming
- Performing
- Mourning

5. Yalom's Stages

- Orientation
- Conflict
- Cohesion
- Termination

LEADERS IN THE FIELD

1. Jacob Moreno

Jacob Moreno created the "theater of spontaneity" in Vienna in 1921, the birth place of psychodrama; which emphasizes the acting out of conflicts or crisis in the here and now. Moreno was also the founder of the American society of group psychotherapy and psychodrama.

2. Irvin Yalom

A. **Irvin Yalom identified eleven 11 curative factors which exist in successful group work.** He believed that if these factors were present, participant growth and development would occur.

- Altruism
- Universality
- Interpersonal learning
- Imparting information
- Development of socializing techniques
- Imitative behavior
- Group cohesiveness
- Catharsis
- Family reenactment
- Institution of hope
- Existential factors

B. **Leadership functions that needed to be present separate from any theoretical orientation:**

- Emotional stimulation that encourages the expression of feelings, values, beliefs and deep emotional concerns.
- Confrontation, challenge, self-disclosure, and modeled behaviors.
- Caring which is expressed through genuine warmth and acceptance.
- Honesty and the promotion of openness and trust.
- Meaning attribution - provided by the leader's cognitive understanding of the events in the group which they articulate to group members.
- Interpretation, clarification and use of self responses which are objectified and articulated.
- Executive leadership function - the leader sets the structure through limits, norms and direction.
- Pacing, blocking, stopping and managing the group as a social system.

C. **Yalom found that effective leaders used moderate amounts of emotional stimulation and executive direction.** Frequent use of caring functions arose along with a consistent use of meaning attribution.

D. **Yalom found that ineffective group leaders showed very low or high emotional stimulation and executive behavior, low caring modeling and low use of meaning attribution.**

3. Zander Ponzo

Zander Ponzo's work came out of his study of Yalom's factors. Ponzo added some skills of successful group leaders to Yalom's list:

- Openness
- Participation
- Risk-taking
- Conflict-confrontation
- Caring support

CO-THERAPY

Two or more therapists lead a group together. Depending upon the group, it may be helpful to have a male and a female leader. Co-leaders should have a good working relationship and theoretical orientations that work collaboratively. If the leaders engage in a power struggle, it will not facilitate group health. Co-leaders should process the group experience regularly. This is also an excellent way to train new group leaders. Advantages are:

- Objectivity - each group leader can observe and provide feedback to their co-therapist.
- Co-leaders can role model and model linking when possible.

GROUP LEADERSHIP SKILLS

1. **Active listening** - hearing, understanding and communicating that one has heard the other's message.
2. **Blocking** - intervening without attacking anyone when a member begins to engage in counter productive behaviors such as scapegoating, storytelling, or gossiping.
3. **Catharsis** - coined by Yalom, being able to freely express feelings inside the self.
4. **Clarifying** - focusing on underlying issues and assisting others to get a clear picture of what they are thinking and feeling.
5. **Confrontation** - challenging members in a direct way on discrepancies and in such a manner that they react non-defensively.
6. **Empathy** - intuitively sensing the subjective world of others. Being able to adopt the frame of reference of others, and communicating this insight.
7. **Facilitating** - helping member's clarify their goals and subsequently take the best steps to reach them.
8. **Goal setting** - helping group members work cooperatively so that there is an alignment between member goals and group goals.
9. **Initiating** - demonstrating an active stance in intervening in a group at appropriate times.
10. **Linking** - looking for themes or common issues and connecting them in a way the group members can understand.
11. **Interpretation** - explaining the meaning of behavior patterns or verbal exchanges.

12. **Modeling** - demonstrating healthy behaviors to members .
13. **Protecting** - intervening to ensure that members will be safe from unnecessary psychological risks.
14. **Questioning** - using questions to stimulate thought and action but avoiding a question answer pattern of interaction between leader and member.
15. **Reflecting feelings** - mirroring what others appear to be feeling without being mechanical.
16. **Restating** - capturing the essence of what is said in different words using affect to add meaning or clarify meaning.
17. **Self-disclosure** - sharing with group members personal information or personal reactions that relate to the here and now occurrences in the group.
18. **Summarizing** - pulling together loose ends, identifying common themes, and providing a picture of the process trends of a group session.
19. **Support** - offering positive reinforcement to facilitate change.
20. **Use of silence** - holding back responses or interventions and listening to the dynamics of the group during and after a period of silence.

INDICATIONS FOR GROUP THERAPY

1. Trying out new relationship skills in a safe environment
2. Working on relationship issues with the guidance of a therapist
3. Isolation
4. Learning new coping skills from others with similar problems

CONTRAINDICATIONS FOR GROUP THERAPY

1. Poor Ego structure
2. Loose personal boundaries
3. Personality disorder
4. Serious problems that could become the focus of the group
5. Extremely low relationship skills

IMPORTANT GROUP THERAPY CONCEPTS

1. **Abreaction** - bringing about an awareness and expression of emotions previously blocked from consciousness.
2. **Cohesion** - develops as group members begin to share feelings toward each other and the group leader. Members work to solve a common problem and share the desire to build a social structure that resembles an ideal healthy family.
3. **Group dynamics** - the therapist's understanding and interpretation of group behavior as a whole furthers the development of all individual patients. The part the individual plays in these interactions helps them understand their social needs and habits.
4. **Group themes** - according to Bion (1951) three major topics overshadow all others, dependency, fight-flight, and pairing, that parallels the group dynamics of inclusion, power and intimacy.
5. **Group norms** - A set of group rules of behavior either overt (formal) or covert (informal) which provide limits to behaviors. These rules may parallel or be different from the outside world. There may be overt or covert pressure on members to conform to the norms and there may be the rebellious type who seek the norms so they will have something to rebel against. These group members begin the process of setting consequences. An example of a group norm would be a particular level of self disclosure or expression of emotions such as crying.
6. **Identification** - in the group setting the patient learns new modes of adaptation by identifying with certain qualities of the group members.
7. **Intellectualization** - a cognitive awareness of oneself, others, and various life experiences that account for the members current functioning.

CHAPTER 7

Treatment Modalities

1. Family Therapy

Therapy consists of the therapist or therapists meeting conjointly with members of a family where one or more members is showing dysfunction in order to help the entire family function more adequately. The theoretical techniques used differ depending on the theoretical orientation of the therapist(s). The theory and techniques of family therapy are discussed more thoroughly in the section on Family Therapy.

2. Group Therapy

Group Therapy is used when a group of clients, each experiencing some form of interpersonal dysfunction, meet conjointly with a therapist or therapists. The interaction of group members with each other and the leadership of the therapist(s) helps facilitate changes in self-esteem, behavior, ways of thinking and interpersonal growth. Group Therapy is discussed more thoroughly in the section on Group Therapy.

3. Individual Therapy

A. Brief Treatment

Brief Treatment is characterized by a limited number of interviews, usually 10 - 15, agreed upon with the client in advance or mandated by the Health Maintenance Organization (HMO) or insurance company. Brief treatment concentrates on current problems, only rarely touching on transference issues unless they are negative and seldom deals with character problems. Dependency and regression are discouraged in this mode of treatment, with the therapist taking a more active role in determining the focus of interviews than with longer-term treatment. Brief treatment is the treatment of choice for many clients, especially those in acute crisis who are not interested in reorganizing their character structures. Persons who are somewhat psychologically-minded can also benefit from

EST COPY AVAILABLE

brief treatment. These clients need to be able to look at themselves realistically, they need a strong ego, they need to be in a favorable reality situation and be able to work well with the therapist.

Managed Care companies often pay for even fewer therapy sessions (ex: up to 6 sessions). Companies may honor requests for some further sessions, if prior approval is obtained. This mode of therapy is very focused and extremely limited in scope.

Theoretical orientations often used in Brief Treatment are: the Cognitive, Cognitive-Behavioral, Behavioral and Social Learning therapies (ex: Skinner, Glasser, Beck, Bandura, Ellis). However, psychodynamic theories are also appropriate when used with limited and focused goals.

B. Moderate and Long Term Therapy

Moderate and Long Term Therapy attempts to understand and modify human behavior using the psychological methods of confrontation, clarification and interpretation. These modes of therapy tend to focus on underlying issues, not just on behavior and are generally more psychodynamically oriented. Thoughts and feelings are of central importance and overt behavior is understood in terms of inner psychological processes inferred from the client's words and actions. Therapy is completed when the client's goals have been met or the client's functioning is improved enough that he/she feels able to "be on my own". Lifetime maintenance may be necessary for some severely disturbed clients. The number of sessions is not specified in these therapies.

Theoretical orientations used in Moderate and Long Term therapy are the Psychodynamic theories, Psychoanalysis (ex: Horney, Sullivan, Jung, Anna Freud, Hartmann, Rapport, Erikson), Humanistic therapies (ex: Perls, Rogers, Berne), Existential therapy.

4. Crisis Intervention

A crisis is defined as a precipitating event that is time-limited and disrupts a person's usual coping and problem solving capabilities. It can be situational, for example, natural disasters, loss of a job or an assault or it can be maturational, such as the marriage, birth of a child or retirement.

A. Disorders appropriate for a Crisis Intervention focus are: severe depressive reactions, acute psychotic states, hyperactive excited states, acute anxiety, panic reactions, acute hysterical reactions, intoxication, severe fear or hysteria resulting from a physical or sexual attack, separation anxiety, fire setting, grief and bereavement (Goldenberg, 1983).

B. Stages of usual reactions are:

1. **Shock** (denial), inability to integrate information, the tendency to "shut down" psychologically which gives the person time to integrate the full impact of the situation, gather inner resources and obtain support. Strong emotional outbursts are common in this stage.

2. **Realization or recognition** of the crisis and finding ways to solve it. This is the peak of the crisis with feelings of helplessness, vulnerability, and instability. This stage may include periods of denial and may last several months, depending on the severity of the crisis.

3. **Integration,** including emotional and intellectual assimilation of the crisis.

C. **Treatment goal** in crisis intervention is to reach the people in acute state of stress and provide them with enough support to prevent them from becoming the 'chronics' of the future (Phares, 1988).

1. **Substages in treatment** to be addressed by all types of crisis intervention are:

   a. Relieving the client's symptoms
   b. Restoring the client to her/his previous level of functioning
   c. Identifying the factors that precipitated the crisis
   d. Identifying and applying remedial measures (Rapaport, 1970)

2. After the crisis has passed, the therapists may be able to help the client connect current stresses with earlier life experiences thus helping the client develop adaptive coping skills that can be used with future problems.

D. **Treatment techniques** depend on the nature of the crisis and generally involve one or more of the following:

1. **Environmental manipulation** where the therapist directly or indirectly removes the identified hazard from the client's environment (ex: by making appropriate referrals).

2. **General support** where the therapist provides the client with emotional support using a variety of techniques (ex: active listening).

3. **Generic approach** where the therapist utilizes conventional crisis intervention techniques appropriate to the client's crisis.

4. **Individual approach** where the therapist uses interventions appropriate for a specific person. Use of an individual approach is based on the assumption that the crisis and the person's reaction are related to long-term personality dynamics.

CONFLICT RESOLUTION/MEDIATION

Mediation is voluntary participation in a structured process in which a neutral third party assists two or more disputing parties who are trying to reach an agreement. The mediator acts as a facilitator, helping the disputants work together to identify common interests. It is the responsibility of the disputing parties to make recommendations, to determine the final decision and to find mutually agreeable solutions.

A. **Characteristics of mediation are:** confidentially, acceptance, active listening, development of rapport and empathy, interpretation of the interactive dynamics, role modeling, and emphasis on the present and future.

B. **Basic components of mediation are:**

1. **Intake and Orientation** consists of establishing rapport and structure, attending and active-listening techniques are used.

2. **Joint Sessions** is where each party tells his/her own story in the presence of the other. Problems and goals are defined and information is gathered regarding positions, needs, and interests. Reframing is part of the process.

a. **Individual Sessions** may be necessary to continue to build trust, to explore options, to reinforce the client and to discuss the client's positions, needs and interests in more depth than before.

b. **Mediator** caucuses may be required, if more than one mediator is involved, to discuss strategies.

c. **Agreement** results when the disputants are brought together and a contract is presented and signed. A follow-up contact may be required to reassess the agreement (Messing, 1993).

CHAPTER 8

Special Treatment Issues

CHILD ABUSE AND NEGLECT

1. Definition:

Definitions of child abuse and neglect differ. Incidence estimates vary widely from 60,000 to 1.5 million children. In Massachusetts and many other states counselors are Mandated Reporters of child or elder abuse or neglect. Under penalty of law, Mandated Reporters must report suspected abuse or neglect to the appropriate agency.

2. Characteristics of abusive parents

A. General:

1. Although a few abusive parents have severe mental illness, the large majority show only maladaptive personality characteristics and behaviors. Some behaviors that have been associated with high risk for child abuse include emotional immaturity, as evidenced by low impulse control and frustration level, a tendency to over-react, and high dependency needs. Abusive parents often place a high value on authoritarianism, are highly rigid, and have low self-esteem. Additionally, these parents often experience few pleasures in their life and often abuse drugs and alcohol (Blumberg, 1975; Steele, 1975 as cited in *Preparatory Course for the Psychology Licensing Examination,* Vol. IV, 1991).

2. The social isolation of abusive parents has been documented. This isolation results in few sources of emotional support including that of their own parents, since there is often a poor relationship with their parents. Abusive parents have also been found to move from place to place frequently (Green, 1976).

BEST COPY AVAILABLE

3. Other parental factors for possible child abuse are a strong belief in the value of physical punishment for controlling behavior, a view of children as their "property", there may be marital conflicts and instability and a history of minor criminal offenses. Abusive parents are generally between 20 - 30 years of age, having married at a young age and been young at the time of the birth of their first child (Cameron, 1994; DeFrancis, 1963; Steele & Pollack, 1974, Komisaruk, 1966).

4. The lives of children are often disrupted by moves to escape domestic violence. Thus, they frequently lose considerable school time; must leave home without books, money or change of clothing. They may live in the family car if shelters are not available. They may suffer from depression, have difficulty concentrating, be distracted or frequently spend time "daydreaming". They may "act out" toward their parents or siblings (*National Coalition Against Domestic Violence*, 1996).

5. More than 350,000 children in the United States in 1990 were abducted by parents. Over half of these abductions were short-term manipulations involving custody issues. Almost half involved concealing the whereabouts of the child or taking the child out of state (*National Coalition Against Domestic Violence*, 1996).

6. Some abusive parents have been seriously abused as children, while others have experienced other forms of deprivation, hostility or rejection. Abusive parents may have endured a lack of early nurturance or experienced the loss of a significant parental figure as a child (*Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991).

7. Parents abused as children but who are not abusive as parents generally have a greater involvement in social and religious groups and a greater willingness to seek outside support and assistance when needed. They generally have a greater spacing between the birth of their children and may also have intense empathy with those in pain (Hunter, et. al., 1978).

B. Gender and Socio-Economic Class:

1. Several investigators report that mothers are the most common perpetrators of physical abuse, while it is generally the father who is most often the perpetrator of sexual abuse. (*National Coalition Against Domestic Violence*, 1996). Although low income groups are over-represented as abusive parents, it is probably because in their greater use of public social service agencies and hospital emergency rooms, where the abuse is more likely to be reported. The private physicians, who are more likely to see higher-income groups, are less likely to report child abuse. Poverty and associated factors, not ethnicity, are seen to lead to higher rates of child abuse (Elmer and Gregg, 1967).

2. Child abuse knows no economic or ethnic boundaries.

3. The abused child

A. Misperceptions of the child are common among abusive and neglectful parents.

These misperceptions include: unrealistically high expectations, inaccurate perceptions of the child's needs and inaccurate perceptions of normal development (*National Coalition Against Domestic Violence*, 1996).

B. Birth Problems:

Higher rates of physical abuse have been found in children who had a difficult birth or those who were born prematurely (Elmer and Gregg, 1967; Lynch, 1975; Skinner and Castle, 1969 as cited in *Preparatory Course for the Psychology Licensing Examination,* 1991).

C. **Abused children may exhibit particular attributes,** but it is unclear whether these characteristics are the effects or triggers of maltreatment. However, compared to non-abused children, abused children display higher incidence of:

1. mental retardation
2. medical illness
3. physical deformities or handicaps
4. delay in speech, motor skills, social development
5. hyperactivity
6. hypervigilence
7. pathological aggression
8. oppositionalism
9. disobedience
10. antisocial behavior
11. fear
12. immaturity
13. low self-esteem
14. impaired ability to enjoy life
15. withdrawal
16. seductiveness
17. exhibitionism
18. sexualized play
19. other sexualized behavior
20. Post Traumatic Stress Disorder (PTSD)
21. Conduct disorders - sexually abused boys may develop Conduct Disorder with lying, stealing, vandalism, assaults on other children (*Preparatory Course for the Psychology Licensing Examination,* 1991)

4. The consequences of sexual abuse

The consequences of sexual abuse are more severe when the abuse occurs at a younger age, is repeated, involves the use of force or physical penetration and is incestuous. The response of the nonabusive parent is very important to the child. The child victim of incest is more seriously affected than other trauma victims. They feel helpless, betrayed, stigmatized and contaminated. When victimized girls become adults, they may allow themselves to be further abused by men physically and sexually and accept degradation as the price of intimate relationships. Boys are more likely to admit feelings about their sexual abuse than are girls. Families are more likely to blame boys for being sexually abused and to deny any serious effects of the abuse (*National Coalition Against Domestic Violence*, 1996).

Overall maltreatment is about equal in girls and boys, the difference being in the pattern of maltreatment. In young children, boys are more common victims of physical abuse whereas in adolescence, girls are more frequently abused. With sexual abuse, young girls and older boys are the most common victims. Girls are the victims of sexual abuse about ten times more often than boys (Brown and Finkelhor, 1986).

DOMESTIC VIOLENCE

1. Scope

Domestic violence is widespread. Domestic violence includes verbal, emotional and physical abuse. The U.S. Justice Department found in 1994 that women are ten times more likely then men to be victims of violent crime in intimate relationships. Women generally resort to violence only to protect their children or to protect themselves. Statistics show that domestic violence is the leading cause of harm to women between 15 and 44 years of age, eclipsing muggings, stranger rapes and automobile accidents combined. Injuries that battered women receive are at least as serious as injuries suffered in 90% of violent felony crimes, yet under many state laws, they are almost always classified as misdemeanors.

In 1991, more than 90 women were murdered every week. Nine out of ten were murdered by men. In 1995, in the United States, a woman is beaten by her husband or partner every 7.4 seconds. More than 50,000 women in the United States seek restraining or protection orders every month. Of all homeless women and children, fifty percent are fleeing domestic violence. More than three million children witness acts of domestic violence every year and more than half of the abused women who are mothers beat their own children. The children of abused mothers are six times more likely to attempt suicide and fifty percent more likely to abuse drugs and alcohol.

2. Perpetrators

Battering men come from a variety of backgrounds. Compared to other men, men who batter are more likely to: have grown up in a violent family, blame others for their problems, tend to use force to "solve" problems, abuse alcohol and/or drugs, think poorly of themselves, hold strong traditional ideas about what a man should be and what a woman should be, are jealous of their partner's friends (including other men as well as women and family members), play with or talk about using guns, knives, or other lethal instruments to "get even", expect their partner to follow their orders or advice, go through extreme emotional highs and lows, be frightening when angry, treat their partner roughly. Battering men often have a paranoid, borderline, narcissistic or antisocial personality. Their abusiveness may be confined mainly to the home and they can be very sensitive to the realities of status and power. They can thus appear charming and affable (for example, at work) or deferential and sometimes pathetic in the presence of professionals or the outside world.

Thanks to: National Coalition Against Domestic Violence, Denver CO and Women's Crisis Center of Greater Newburyport, Newburyport, MA for information in this section.

3. Battered women

Flynn (1975), as cited in *Preparatory Course for the Psychology Licensing Examination*, (1991) has identified several "subtypes" of abused women.

A. The relationship with their abuser (generally husband/partner) is relatively stable, with infrequent occurrence of abuse, which is rationalized by being attributed to alcohol or external causes. They may initiate violence toward their partner.

B. The relationship with their abuser is highly unstable, and the abuse includes a sexual component. They are the most severely abused.

C. These women are most likely to be living in constant fear, generally do not retaliate, least likely to have a history of parental or previous spousal abuse, experience the most chronic and severe forms of physical abuse, the children are most likely to also be victims of the abuser.

D. These women experience the lowest frequency and severity of abuse, which often includes a sexual aspect, the children are likely to also be victims of the abuser. These women are the most likely to report their intention to return to their partners, but are among the least likely to do so.

E. These women tend to experience violence as part of their lives, having an extensive history of violence in their families of origin. These women may continue to live with their abuser.

Abused women may believe they "deserve to be hit" and they may stay in the situation because they love their husband or spouse.

SUICIDE

1. Emile Durkheim

The first major contribution to the study of suicide was by Emile Durkheim. His thesis is that suicide, like crime, neurosis, and alcoholism, is a factor that measures social pressure and tension. He divided suicide into social categories: (1) egoistic - those assumed not to have been strongly integrated into any social group, (2) altruistic - those whose proneness to suicide stemmed from their excessive integration into a group and (3) anomic - those who experienced a disturbance in the balance of their integration with society that leaves her or him without their customary norms of behavior.

2. Current treatment approaches

A. **No accurate way of predicting suicide has been found.**

Previous suicide gestures is the best indicator of risk. Other indicators are: previous or present suicidal ideation, "getting life in order", giving away items special to the person, feelings of a high level of hopelessness or deep depression.

B. **Adolescent Suicides**

Adolescent suicides are not necessarily committed for the same reasons as those of adults. Adolescents may overreact to small frustrations and are likely to be deeply depressed. Signs of depression in adolescents are difficult to recognize, but may include sadness and hopelessness masked by boredom, apathy, hyperactivity and physical complaints.

C. **Types of suicides in adults** identified by J. Baechler (1979) are:

1. **escapist suicides** - flight (despair, hopeless), grief (loss of central element in life), punishment (self-loathing)

2. **aggressive suicides** - crime (kills another, then self), vengeance (to induce guilt), blackmail (coercion), appeal (cry for help)

3. **oblative suicides** - sacrifice (self-immolation), transfiguration (belief in a higher order transformation)

4. **ludic suicides** - ordeal (take risk to prove oneself), game (Russian Roulette)

D. **Understanding the suicidal risk is essential in treatment. Key issues in assessing the risk of suicide are:**

1. **elevated agitation** - the decision to kill oneself takes energy

2. **constriction** - has the person given up - this is a critical question since suicide necessitates a very reduced tunnel vision

3. **lethality of the intent, method, plan** - this is difficult to assess with adolescents - the therapist must look at the covert signs - does the client have a specific method she or he is thinking of.

E. **Identifying the primary source of the unendurable pain allows for treatment** (Shneidman, 1985). What is the problem the client is trying to solve? Encourage the client to share the sources of the despair, such as: sadness, depression, helplessness, murderous hate. Help the client express her/his rage and frustration.

F. **Treatment of suicidal patterns**

1. **For the client's protection,** the therapist must evaluate the client, medicate, if necessary (or obtain a medication evaluation) and possibly hospitalize.

2. **Contracting for safety is not sufficient as an intervention.** Contracting must be used as an assessment tool, to help evaluate the risk.

3. **Short-term cognitive-behavioral therapy** (Beck, et al, 1979)

   a. identify the depressogenic thought, ex: helplessness, hopelessness
   b. distancing, de-centering - look at the distortions
   c. re-structuring - building viable substitute thoughts
   d. homework assignments

4. **A holistic or team approach** is recommended including the psychotherapist (using short-term cognitive-behavioral therapy and later psychodynamic therapy dealing with long-term issues of loss), psychiatrist (for medication needs), family therapist, environmental social worker (if the client has been hospitalized)

5. **Long-term psychodynamic treatment** allows the therapist to:

   a. provide active engagement and empathic responsiveness;
   b. uncover suicidal fantasy material; use confrontation strategically; manage countertransference
   c. resolve recent and early life losses (from Barent Walsh, DSW, workshop, Lynn, Ma., Dec. 1993).

G. **It is the responsibility of the therapist** to recognize the possibility of suicide, or determine if the client is competent to assume responsibility for her or his own actions, to discuss the possibility of suicide with the client and to discuss alternatives with the client (Gilliland and James, 1993).

H. **Legal Issues**

The therapist must be aware that there may be legal issues which result from what she or he does with regard to a potential suicidal client, therefore it is essential to keep good client notes. Client notes should contain (1) what you did, (2) why you did it, (3) why you chose not to do something else, (4) whom you contacted for confirmation of your decision - preferably someone at a higher level than you, i.e.: supervisor.

COUNSELING SPECIFIC POPULATIONS

Counseling particular populations necessitates particular expertise and awareness on the part of the therapist. Additional training and experience may be necessary. At the very least, the therapist must be aware of particular problems of that population and believe there is hope that the person can feel better and experience life differently than their present state of discontent.

1. Counseling elderly populations

A. **In counseling elderly clients,** it is important to remember that aging affects the entire person, in physical, spiritual, and economical ways, as well as the social, psychological and even the political realms.

B. **Therapists working with the elderly need to respect and care about elderly persons.**

They need to have had positive experiences with elderly people, and need the ability and desire to learn from elderly people. The therapist needs to be patient, to understand the biological aspects of aging and believe that the last years of one's life have worth and value. The therapist needs to know the special needs of elderly clients biologically, psychologically and socially and to be sensitive to the difficulties and anxieties of getting old. The therapist needs to question the myths about old age and to encourage elderly clients to do so as well. He/she must have a healthy attitude toward their own eventual aging (Corey & Corey, 1971).

C. **Therapists need to be aware of, and have dealt with (at least to some degree), their own feelings about death and be familiar with the psychological responses to death** of denial, anger, bargaining, depression, acceptance (Kubler-Ross, 1969). (Responses to death are explicated further in the section on Developmental Psychology.)

D. **In seeking treatment, the elderly client is often looking for a sense of meaning in her/his life.** Elderly persons often come to treatment because of the many changes and/or loss they are experiencing, such as a decrease in physical abilities, changes in their social life and social role, changes in their relationships and life status. The therapist needs to support the client's feelings and help her/him cope with the current difficulties. In helping the client create a new identity or sense of self, the therapist needs to set specific treatment goals in conjunction with the client.

E. Special Issues:

1. **Sexual interest** continues into the 70's, 80's and beyond. However, it may be difficult for women to find a socially approved sexual partner, while men may experience temporary interruptions due to sexual dysfunction (because of depression or anxiety, unrelated to age).

2. **The losses that elderly people experience** can result in depression. Treatment includes developing limited objectives for treatment, determining the current problem, helping the client express her/his feelings, helping the client employ past successful problem-solving methods to the current problems. Brief sessions may be scheduled and repetition can be expected. Delving into early family issues is not generally helpful with elderly clients. In extreme circumstances crisis intervention and/or medication may be needed (Charatan, 1985).

3. **Suicidality:** There is a higher rate of suicide among the elderly and is rising for elderly males. The higher suicide rate is often due to bereavement and lack of social support. The client may need a referral for a medication consultation and in a few cases institutionalization.

2. Minority group clients

A. Awareness of Diversity:

1. In counseling minority clients, the therapist needs to be aware of the cultural, ethnic, and class diversities. It is helpful to acknowledge to the client the therapist's awareness of differences. It is also helpful to ask the client if she/he has any concern regarding these differences.

2. Showing respect for differences and appreciating the strengths of different cultures and socioeconomic groups are important attributes the therapist needs to develop. It is important not to generalize about all clients belonging to a particular race, culture, or class. It is most important to focus on understanding the particular client with whom one is working.

B. Effects of Prejudice and Need for Validation:

The therapist should not refer to negative stereotypes. It is helpful for the therapist to be aware of social and community supports to which to refer the client. It is important that the therapist recognize the real problems that exist for minority or lower socioeconomic groups. Discrimination and prejudice are real in social, economic and political areas and need to be validated, while helping the client to recognize and use her/his personal strengths. The therapist must recognize that suspiciousness and mistrust may be a legitimate response to past experience and may not reflect paranoia or defensiveness.

3. Clients with physical disabilities

A. Issues:

In working with clients with physical disabilities, the therapist needs to be aware of the phases of adaptation to traumatic disability and loss. These are: shock, anxiety, denial, depression, internalized anger, externalized hostility, acknowledgment, and finally, adjustment.

B. Therapeutic Approach:

The choice of specific therapeutic approaches depends on the client's needs, the degree of psychosocial impact, the onset, nature, course, and progression of disability, the client's support system and the counselor's knowledge and mastery of different intervention strategies. Person-Centered and Gestalt Therapy are particularly useful in the early phases of the adaptation process because they focus on the affect and are nondirective interventions. More effective in the latter phases of the adaptation process are the cognitive-behavioral and active-directive therapies such as: Rational-Emotive Therapy, Cognitive Therapy, Reality Therapy and Behavioral Therapy (Livneh & Sherwood, 1991).

4. Lesbian and gay clients

A. **Society's attitudes toward gay people and the resulting discrimination are felt throughout a gay person's life,** including their relationships and interactions with family, friends, lovers, and persons in the workplace. The gay lifestyle is seldom recognized, in the heterosexual world, as an acceptable alternative to the heterosexual lifestyle. There are few places where a gay person can find reinforcement or affirmation.

B. **Special Issues:**

1. **Absence of role models:** There are few realistic role models, for gay persons because of the need to keep sexual preference hidden. This is especially difficult for gay teenagers. There are no models for gay people to follow in their closest relationships as there are for heterosexual people, such as wife, mother, husband, father or lover. It is difficult for gay people to know how to go about being gay as nongays know how to be heterosexual. Because of society's attitudes and few, if any, role models, many gays are "heterosexual" in public, but are "more themselves" with other gays.

2. **Identity:** One of the greatest difficulties for gays is relating to people who don't know they are gay and to whom they don't want to reveal their sexual preference, such as at work, with family and with close friends. The need to be "closeted" creates great pressure on the gay person and may cause great anxiety.

3. **Homophobia among therapists** continues to exist. Homophobia refers to the fears and the negative attitudes toward gays and refers to persons who dislike and are afraid of gay people or gayness. It is related to society and culture and is not related to actual characteristics of gay persons. People who are homophobic may believe that homosexuality is a symptom of "incomplete development" and see homosexuality as a disorder. This attitude will reflect in the treatment with the gay client. DSM-IV does not consider (nor have two previous DSM's considered) homosexuality to be a mental illness. A homophobic therapist, regardless of his/her own sexual orientation cannot effectively treat gay clients and should refer those clients elsewhere.

C. **Treatment:**

1. Treatment of gay clients is the same as for nongay clients. If the therapist fears a sexual approach by a gay client, it is handled in the same way as fears of being approached by nongay clients. The therapist must be aware of how gay and nongay lifestyles differ and may lack practical knowledge regarding homosexuality and the homosexual lifestyle. The therapist may need to ask about the lifestyle of the gay client and be open to hearing the answer.

2. Recognizing and validating the gay person's experience in the world is important. Helping the client deal with oppression and prejudice may involve working with the lesbian or gay man on new coping skills. It may be helpful to work on assessing the reality of fear-producing situations. The client may need help accessing resources. Addressing a substance or alcohol abuse problem and helping the client deal with it may be necessary.

D. Multiple Oppressions:

1. Minority gay clients face racial and ethnic issues which are also important in considering their sexual orientation. They may come to therapy with additional suspicions and may expect the therapist to have prejudice based on both race and sexual orientation.

4. Gender issues

A. Sexism in therapy also continues to exist.

1. Therapists attitudes

The therapist must recognize her/his own sex stereotypes and prejudices and guard against the negative impact of sexism on their work. Sexism by therapists is less than it used to be, but still needs to be reduced and still has a profound effect on the counseling process. Both female and male therapists hold sexist views and mental health counselors must be aware of their own sexist attitudes (Bowman, 1982).

2. Effects of sexism on counseling

a. **Gender bias** is seen to a greater extent with female than male clients. Females have often been assessed on the basis of the stereotypical "healthy female" as defined in the Broverman et. al. (1970) studies as dependent, emotional, passive, and non-competitive. When the female client fails to meet that definition, she is more likely to be given a "sexist diagnosis".

b. Therapists may assess clients differently depending on gender. Judgments of the "healthy adult male" have been different from judgments of the "healthy adult female". Anger (for instance) may not be seen as part of the stereotype of the "normal" female and may be seen as an unhealthy characteristic in women. Many "angry" women have been seen as hysterical, thus being misdiagnosed, overmedicated and historically have been inappropriately institutionalized.

There may be a bias against female clients if the client is too active outside the home. The "family values" emphasis in society encourages women to focus more on home and family and less on activities (particularly work) outside the home. This may be viewed as a major problem for a female client who is seen as not achieving "normal femininity", thus necessitating more in-depth therapy. However, even a greater amount of activity outside the home in male clients may be seen as an interpersonal or relationship problem requiring less intensive treatment.

c. **Self-esteem**

Mental health workers must be aware of the damage to women's self-esteem when they are encouraged to meet only the needs of others at the expense of their own needs.

B. Feminist therapy

Feminist therapy grew out of the women's movement and consciousness-raising groups. In individual therapy, it emphasizes sociocultural implications of the client's role as a woman or man. These issues are viewed in light of women's and men's roles in society, supporting the client's life experiences and helping the client focus on personal power.

CHAPTER 9

Substance Abuse

HISTORY IN U.S.

Substance abuse has been with us since the Puritans. It seems the early settlers believed the drinking water was hazardous to their health and chose to quench their thirst with hard cider. In the late 1700's the city of New York sported almost 400 taverns, which provided one for every twelve adult males. (Gamwell and Tomes, 1995) Our modern culture provides many more substances to be abused than the Puritan society could have ever imagined. Today's clinician must be familiar with the many forms of substance abuse. Substances such as marijuana, cocaine, amphetamine and heroin, hold separate subcategories in the DSM-IV. It is essential that the clinician to be familiar with the six fundamental "pattern" matrices of the following categories:

- Dependence
- Tolerance
- Persistence
- Abuse
- Intoxication
- Withdrawal

DEFINITIONS

Dependence and abuse are defined across all substances. Intoxication and withdrawal are substance specific.

1. Substance dependence

A maladaptive pattern, leading to clinically significant impairment or distress with at least three of the following occurring in the same 12-month period:

- Tolerance
- Withdrawal (substance specific)
- Increased use over a longer period than was intended
- Persistent desire for a substance
- Unsuccessful efforts to cut down
- Spending a great deal of time obtaining or recovering from substance abuse
- Reduction or abandonment of social, occupational or recreational activities
- Continued use despite awareness of recurrent physical or psychological problems

2. Tolerance

Need for greater amounts to achieve similar results or diminishing effect with use of the same amount. **Reverse Tolerance** - the need for lesser amounts to achieve similar results.

3. Persistence

Unintended use of larger amounts or for longer than intended:

- Inability to control use, or persistent desire for the substance
- High time cost to obtain, use, or recover from the substance
- Giving up of important life activities because of use
- Continued use in the face of use-related psychological or physical problems

4. Substance abuse

Presumes no prior diagnosis of dependence and does require impairment or distress from a maladaptive pattern within a 12-month period. The diagnosis must contain one of the following maladaptive patterns:

- Failure in a major life role, obligation in some recurrent pattern
- Hazardous status such as driving while drunk
- Recurrent consequent legal problems
- Persistant use despite use-related socio-interpersonal problems

5. Substance intoxication (substance specific)

- Development of a reversible substance-specific syndrome due to the recent use of a substance
- Clinically significant maladaptive behavior or psychological changes due to the substance
- Symptoms not due to a general medical condition or other mental disorder

6. Substance withdrawal (substance specific)

- Development of a substance-specific syndrome due to the cessation or reduction of substance
- Clinically significant distress or impairment in social, occupational or other areas of functioning
- Symptoms not due to medical or other mental disorder

DIAGNOSIS

Clinicians should always screen for substance abuse by looking for danger signs such as problems in the marriage, on the job or other organic or role deterioration. Often reports from significant others in the client's life can help clarify substance use.

1. Dependence syndrome

A. Scale

1. **Mild dependence** - Having few symptoms in excess of those required for diagnosis
2. **Moderate** - between mild and severe dependence
3. **Severe** - Having many symptoms including:
    a. Persistent desire or one or more efforts to cut down or control use
    b. Spending a great deal of time acquiring, using, or recovering from substance use
    c. Continued use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or increased by the use of the substance

B. Symptoms (within the scale)

1. Tolerance

2. Withdrawal symptoms after discontinuation of use or abstinence

3. Taking the substance in larger amounts or over longer periods than originally intended.

2. Assessment

A. Identify dependence syndrome and substance use disorders

B. Gather patient history. May include information from significant others

C. Physical Exam

D. Laboratory Examinations

- Urine/Blood
- Liver enzymes
- Serology
- HIV

E. Mental Status Exam

F. Assessment of other non-organic psychiatric disorders

G. General Testing

- MMPI 2
- 16 PF

DIFFERENTIAL DIAGNOSIS

In the DSM-IV, substance-related disorders are distinguished from non pathological substance use, such as social drinking and from the use of medications (prescribed or over the counter) for medical purposes, by the presence of tolerance, withdrawal, compulsive use, or related problems such as medical complications, role disruption, financial and legal problems.

Substance-Induced Mental Disorders are included in the general category for the particular disorder, i.e., Mood Disorders and Anxiety Disorders.

DUAL DIAGNOSIS

Dual diagnosis is a generic term that refers to patients who fit the criteria for some kind of substance abuse and other DSM diagnostic categories. These clients are often severely and chronically ill. Generally acute symptoms of substance abuse must be addressed, and use under control, before significant work can be done on other clinical problems. Once this is done, both or all problems can be actively treated. Treatment plans need to be monitored and eventually integrated for long term work and relapse prevention.

STAGES OF SUBSTANCE ABUSE

1. Preabuse stage

Increased susceptibility from genetic, personality, family, sociocultural and psychiatric risk factors

2. Experimental stage

The decision is made to try a substance confined to social situations with others supplying the substance

3. Early regular use

- A seeking for the altered states. Increased situational or solitary use
- The range of substances may increase
- Behavioral signs may appear

4. Late regular use

- Daily activities are planned around opportunities to use substances
- Withdrawal when not using
- Questionable control over use
- Frequency increases
- Unpleasant feeling states may worsen leading to more substance use
- Self-destructive and risk-taking behaviors increase

5. End Stage

- Constant dysphoria leading to increased use
- Drug use constant
- Substance selection less selective aimed toward availability

TREATMENT

1. Goals of treatment (Galanter and Kleber, 1994)

- Maximize motivation for abstinence
- Rebuild a substance-free lifestyle
- Maximize multiple aspects of life functioning
- Optimize medical functioning
- Identify and treat psychiatric symptoms and disorders
- Deal with marital and family issues
- Enrich job functioning and financial management
- Address spiritual issues
- Deal with homelessness
- Prevent relapse

2. Stages of change

Most clinicians are aware of the massive denial at work in substance abuse. A model offered by Prochaska (1992) that tracks the change process is:

A. Pre-Contemplation

The individual avoids confrontation of true issues and denies consequences.

B. Contemplation

There is at least some acknowledgment of personal responsibility and problems with a minimal willingness to change though none has begun.

C. Preparation

The decision point. There is enough willingness to acknowledge problem behaviors and their consequences and a willingness to initiate change.

D. Action

New behaviors are established to support positive coping and there is an avoidance of situations that support the substance abuse.

E. Maintenance

The individuals efforts are directed toward developing skills and patterns that avoid relapse and creating a positive lifestyle.

3. Treatment alternatives

A. Aversive conditioning, i.e., Antibuse

B. Relaxation training i.e., Yoga

C. Systematic desensitization

D. During inpatient detoxification a token program can be used to help the individual organize his/her behavior toward a more substance free lifestyle

E. Adlerian approaches appear to have the most support in the psychoanalytic approach with an emphasis on personal responsibility for their behavior

F. Cognitive and existential therapies indicated later in treatment

G. "Quit contract" - a contract with the clinician to quit is recommended - The contract explains the specifics about changes in behavior and lifestyle

H. Family therapy has also been found to greatly support change.

4. Treatment settings

A. Inpatient

B. Outpatient

C. Residential

5. Treatment modalities

A. Individual Psychotherapy

B. Family Therapy

C. Group Therapy

D. Recreational Therapy

6. Treatment research outcomes (Galanter and Kleber, 1995)

A. No Evidence of Effectiveness - this may be due to lack of data.

1. Anti-anxiety medications
2. Cognitive therapy
3. Confrontational interventions

4. Psycho-education
5. Electrical aversion therapies
6. General counseling
7. Group therapies
8. Insight-oriented psychotherapy
9. Nausea aversion therapies
10. Residential milieu therapies

B. Insufficient Evidence of Effectiveness (possibly due to lack of data)

1. AA Alcoholics Anonymous
2. Halfway houses
3. Acupuncture
4. Calcium carbimide

C. Indeterminate Evidence of Effectiveness

1. Non-behavioral marital therapy (Behavioral marital therapy - emphasizes the improvement of communication and problem solving skills)
2. Hypnosis
3. Lithium

D. Fair Evidence of Effectiveness

1. Antidepressant medications
2. Behavior contracting
3. Covert sensitization - uses the patients own imagination to develop aversive consequences
4. Oral and implant disulfiram (Antibuse)

E. Good Evidence of Effectiveness

1. Brief Interventions

FRAMES
Feedback regarding drinking
Responsibility placed regarding drinking

Advice to change
Menu of interventions and options for change
Empathic style of counseling
Self-efficacy emphasized

2. **Community Reinforcement Approach (CRA)**

   Ranking the patient's substance related problems and choosing strategies from a menu of alternatives designed to address problems

3. **Self control training:** Teaching a set of self-management skills

   a. Goal setting
   b. Self-monitoring
   c. Self-reinforcement
   d. Alternative coping skills

4. **Social Skills Training:** Learning how to form and maintain interpersonal relationships

   a. Communication skills
   b. Listening skills
   c. Problem solving skills
   d. Assertiveness skills

5. **Stress Management Skills**

   a. Relaxation strategies
   b. Systematic desensitization
   c. Cognitive strategies

F. Additional factors

1. Therapist characteristics

   a. High empathy
   b. Non aggressive confrontation

2. Setting

3. Matching patients to treatments

   a. Treatment is consistent with cognitive style

4. Using a broad-spectrum approach

5. The higher the abuse related problem the more intense the treatment and visa versa

6. Allowing the patient to choose his/her treatment approach

SPECIFIC SUBSTANCES

1. Alcohol

The term alcoholism was coined 137 years ago by Magnus Huss. Since then there have been many "enlightened" approaches to treatment. (Herster and Miller, 1989) Alcohol intoxication is a toxic condition of the body. Alcohol is absorbed through the stomach and intestine and oxidized in the liver with a maximum processing of one ounce of 100 proof alcohol per hour. The excess then affects the brain causing "intoxication." The process appears to be slower in females. The alcohol acts as a depressant that inhibits the higher brain centers first and then affects the lower brain. With increased toxicity there is a loss of more complex cognitive and perceptual abilities and eventually loss in simple memory and motor coordination. Long term abuse results in CNS dysfunction with problems exacerbated by vitamin deficiencies, poor diet, the breakdown of social and support systems, and the physical effects of the alcohol.

A. Initial Diagnosis

1. Direct Questions

Diagnosis in the DSM-IV includes many alternatives. The clinician will need to screen their client carefully to make an accurate diagnosis. Direct questions during the initial interview can include: (Zimmerman, 1994)

- How much do you drink now?
- Have you ever drunk too much? If yes - When?
- Has anyone ever told you that you drink too much?
- Has your drinking ever caused you problems in life? If yes - What kinds of problems?

2. Further Questions

If there is the potential for an alcohol abuse diagnosis, further questioning must be done to identify:

a. Alcohol Abuse - Due to your drinking how often do you:
  - Miss work?
  - Have trouble at school?
  - Not care for your children?

b. Alcohol Dependence
  - Do you need to drink more now to get high?
  - Have you noticed any of these problems when you try to quit or cut down?
    Shaking
    Can't sleep
    Anxious feelings

3. Intoxication Identifiers:

a. Slurred speech
b. Lack of coordination

c. Unsteady gait
d. Impairment in attention or memory
e. Stupor or coma
f. Autonomic hyperactivity
g. Sweating
h. Hand tremor
i. Insomnia
j. Nausea
k. Vomiting
l. Transient hallucinations or illusions
m. Psychomotor agitation
n. Anxiety
o. Grand mal seizures

3. Alcohol Screening Tools:

a. Alcohol Use Inventory (AUI)
b. CAGE self-report questionnaire:
  - Have they ever attempted to Cut back on alcohol?
  - Have there been Annoying comments made about their drinking?
  - Do they ever feel Guilty about drinking?
  - Do they need an Eye-opener in the morning to steady their nerves?

c. Chemical Dependency Adolescent Assessment Project scales (CDAAP)
d. Comprehensive Drinker Profile (CDP)
e. Essential-Reactive Alcoholism interview (ERA)
f. MacAndrew Scale (MAC)
g. Michigan Alcoholism Screen Test (MAST)
h. Substance Use Disorder Diagnostic Schedule (SUDDS)

4. Pretreatment Evaluation Tools:

a. Locus of Control (LOC)
b. Minnesota Multiphasic Personality Inventory (MMPI)
c. Rorschach
d. Sensation Seeking Scale Form V (SSC)
e. Sixteen Personality Factors Questionnaire (16PF)
f. Tennessee Self Concept Scale (TSCS)
g. WAIS-R

B. Treatment

Alcoholics are generally considered to overuse defense mechanisms to avoid dealing with their problems. Some believe they are part of the characterological structure of the alcoholic. In any case, breaking through the defense systems of the individual and getting them to admit there is a problem they need to deal with is the first step of beginning treatment. Listed below are the stages of treatment starting with getting the alcohol out of the system of the client.

1. Detoxification ideally at least three weeks in duration.

a. Inpatient or outpatient

2. Chemotherapy

a. Benzodiazepenes (anti-anxiety) for weaning the person away from alcohol
b. Methadone and imipramine (antidepressant) - for alcoholics where depression is a feature.

3. Aversives

a. Disulfiram
b. Calcium Carbimide (Temposil)

4. Anxiolytics (anti-anxiety)

5. Neuroleptics (anti-psychotics)

6. Vitamins

a. Thiamine
b. Multivitamin

7. Psychotherapy - The first task is to break through the denial

8. Aversion therapy - Administering electric shock during intoxication or playing a videotape of the person taken when they were drunk.

9. Supportive therapy - Social network of support such as Alcoholics Anonymous or Moderation Management.

10. Nine to fifteen months are needed to adjust to an alcohol-free lifestyle. A relapse-resistant lifestyle is considered to be in place within two to three years. The ability to remain substance free and have fun and enjoy life is considered a state-learned behavior. It is important for the clinician to help the recovered client to learn new skills with which to enjoy life.

2. Amphetamine use disorder

Tolerance to amphetamines builds quickly which leads to increased intake and dependence. Continued use over a significant period of time leads to paranoid ideation and psychotic symptoms that may persist after the substance is no longer in use.

A. Diagnosis

One of the first determinations that must be made is whether the substance is a prescription or street purchased drug.

1. Interview questions that might be asked are: (Zimmerman, 1994)

a. Have you ever used prescription medication for sleeping, weight loss, to kill pain or to calm you down?

b. If yes:
- How long have you taken the drug?
- Did you ever take more than was prescribed?

c. If no:
   - Have you ever used any drugs you got from friends or bought on the street?

d. If yes:
   - What did you get?

e. How frequently do you use it?
   - If the frequency is more than 10 times in life ask:
     Do you think you use drugs too often?
     Has anyone close to you said you use them too much?

f. Have the drugs ever caused problems for you?
   If, yes:
   - What kinds of problems?
   - How old were when you started having these problems?

1. Testing

a. MMPI-2
b. 16 PF
c. MCMI-III

B. Treatment

1. **Existential Techniques -** Since underlying problems such as anhedonia or depression are present existential techniques to confront apathy and cognitive behavior techniques are useful.

2. **Behavioral Techniques** such as covert sensitization which is a sub category of covert conditioning is also helpful.

C. Other Issues to be Addressed

1. The presence of an eating disorder or obesity must also be addressed.

2. The presence of Attention Deficit Disorder must also be addressed.

3. Caffeine-related disorders

Most caffeine use can be attributed to the use of coffee, soda, over the counter medications, stimulants, weight-loss aids, and chocolate. The symptoms are clinically significant when they interfere with or impair social, occupational or other roles of functioning, and are not due to medical condition or other mental disorders.

A. Diagnosis

When diagnosing the clinician must consider if the caffeine is the cause of or exacerbating other problems such as anxiety disorders or sleep disorders. Caffeine induced disorders are considered clinically significant when five or more the following signs develop during or after the ingestion of at least 250 mg. of caffeine:

- Restlessness
- Nervousness
- Excitement
- Insomnia
- Flushed face
- Diuresis
- Gastrointestinal disturbance
- Muscle twitching
- Rambling flow of thought and speech
- Tachycardia or cardiac arrhythmia
- Periods of inexhaustibility
- Psychomotor agitation

B. Treatment

Education about the occurrence of caffeine in the daily diet can help the patient reduce their intake. Behavioral interventions much like the ones used with smoking cessation can be used.

4. Cannabis

Use appears to be on a continuum of occasional or experimental to compulsive daily abuse. Marijuana is often the first illicit drug used by the young after use of alcohol and cigarettes. There is a lot of social interaction in early use and it is used for relaxation as it progresses to weekly or daily use. Finally the goal might be to remain "stoned" all day long. It is often used to alter the effects of other drugs, to reduce the anxiety created by cocaine use and amplify alcohol intoxication. Marijuana is believed to be the most frequently used illegal psychoactive drug in America.

A. Diagnosis

1. The clinician needs to:

a. Evaluate the past and current use of cannabis as well as other drugs.
b. Identify past problematic behaviors.
c. Try to correlate problem behaviors to drug use.

2. The same kinds of questions that were used to assess street drug use can be asked:

a. How frequently do you use it? If the frequency is more than 10 times in their life ask:
  - Do you think you use drugs too often?
  - Has anyone close to you said you use them too much?
  - Have the drugs ever caused problems for you?

b. If drugs have caused a problem:
  - What kinds of problems?
  - How old were when you started having these problems?

3. The determination needs to be made whether the use is dependence or abuse.

4. Other assessments that need to be made are:

a. Physical exam
b. Urine analysis
c. Mental status
d. Non-organic psychiatric symptomatology
e. Family interview

B. Treatment

1. Intoxication

a. Panic attacks
b. Anxiety reactions
  - Calm reassurance in a supportive atmosphere "talking down."
  - Psychopharm - A fast acting anxiolytic such as Diazepam.

2. Psychosis

a. Close observation in a warm supportive environment and continued reassurance that these thoughts and feelings will go away and are caused by the drug.
b. Psychopharm - same as above possibly in higher doses Neuroleptics - Haldol

3. Delirium

a. Treatment is symptomatic to the delirium.
Psychopharm:
Anxiolytics
Neuroleptics

4. Flashback Syndrome

a. Reassurance
b. Anxiety relief
c. Anxiolytics

5. Recovery - Early phase is from 1-12 months. Relapse signs are:

a. Euphoric recall
b. Remembering only the positive aspects of the drug experience
c. Reentering the social situations where use occurred

6. Psychotherapy

a. It is often difficult to establish a therapeutic relationship with abusers.
b. Positive transference should be encouraged in the early stages of treatment. Client dependency should be accepted.
c. Therapist needs to have a good understanding of the cultural language and pharmacological end effects of the drug.
d. Enhance interpersonal functioning.
e. Reduce anxiety.
f. Recognize maladaptive behaviors.

7. Family Therapy

a. Improve communication patterns.
b. Address parental expectations.
c. Address parental or sibling drug use.

8. Group Therapy

a. Teaches socialization skills.
b. Teaches problem solving skills.
c. Reduces sense of isolation.
d. Offers a support system for abstinence.
e. Helps to identify maladaptive behaviors.

9. 12-Step Programs

10. Behavioral Therapy

a. Relaxation exercises.
b. Assertiveness training.
c. New coping skills.
d. Contracting.

5. Cocaine abuse

Cocaine has been used for centuries by important figures in the culture such as Freud, Sherlock Holmes (created by Arthur Conan Doyle) and John Philip Sousa. Cocoa leaves were chewed by the Aztecs and millions of southern American Indians. Many Americans were unknowingly habituated to it in the 1800's by drinking Coca-Cola advertised as a "brain medicine." Short-term use of cocaine inhibits the reuptake of dopamine leading to an increased concentration and transmission of dopamine causing euphoria. Long-term use depletes the brain of dopamine, norepinephrine and serotonin. Mixed with alcohol a new substance called cocaethylene forms in the liver amplifying its effects and increasing the risk of heart attack 20 times.

A. Diagnosis

This client also needs to be assessed for dependence or abuse of cocaine as well as the potential for dual diagnosis. Personality changes appearing as narcissism, a competitive attitude and a super achievement-oriented personality with a strong fear of intimacy and vulnerability. This can lead to diagnostic considerations such as:

1. Narcissistic Personality Disorder

2. Obsessive-Compulsive Personality Disorder

B. Testing

MMPI-2
16 PF
MCMI-III

C. Treatment

1. **Inpatient detoxifying** which can last from a few days to three months.

2. **The extinction phase** can last from three to twelve months.

3. **Chemotherapy**

   a. Calcium channel blockers reverse the effects of toxicity.
   b. Buprenorphine
   c. During withdrawal
      - Bogaine
      - Desipramine

4. **Psychotherapy**

   a. Confrontation techniques.
   b. Helping the addict to take more control over their decisions.
   c. Planning adaptive behaviors to satisfy needs.
   d. Resolution of spiritual and intimacy-betrayal and avoidance issues.
   e. Treatment for underlying depression.
   f. Anonymous programs.

   The critical skills appear to the ability to learn, apply and live through relapse crisis.

6. Hallucinogen-related disorders

Includes Ergot and related compounds such as LSD, morning glory seeds, mescaline, MDMA, Ecstasy, Psilocybin, DMT and other related compounds. It does not include PCP and Cannabis. Effects are varied depending on the drug of choice and amount consumed. Perceptual alterations are noticed with changes in:

- Color
- Geometric patterns
- Distorted forms

  These changes can take place with the eyes open or closed
- Greater sensitivity to touch, and sometimes taste and smell
- Synthesis - overflow from one sense modality to another
- Subjective time is altered
- Hyper-suggestibility and distractibility
- Changes in ego functioning
- Chronic use can create personality change.

A. Diagnosis

Is often made from the individuals self-report. Clinical diagnosis is often made when the individual is actively hallucinating, delusional or describing any of the above changes.

Laboratory tests to be done:

1. Blood

2. Urine

B. Treatment

1. General

a. Individual experiences range from pleasant to frightening which are commonly referred to as "bummers" or "bad trips."
b. Acute anxiety or panic reactions usually wear off before intervention is necessary.
c. Reassurance and support, or talkdown, is done in a quiet, pleasant environment in a homelike setting. The patient should sit up or walk around being reminded that extraordinary thoughts and feelings are a result of the drug and will soon disappear.

2. Chronic Adverse Reactions

a. Symptoms resembling personality disorders have been noted as well as psychotic reactions.
b. When reactions are life threatening inpatient treatment is recommended.

3. Flashbacks

a. Long term psychotherapy.

4. Psychopharmacology

a. Anti-psychotics are sometimes helpful for extreme anxiety but paradoxical reactions have been reported.

7. Inhalant-related disorders

Includes mental disorders brought on by the inhalation of aliphatic and aromatic hydrocarbons found in gasoline, glue, paint thinners, and spray paints. Less common substances are halogenated hydrocarbons found in cleaners, typewriter correction fluid, spray can propellants and other volatile compounds containing esters, ketones, and glycols. Most of the above are inhaled and can produce psychoactive effects and can be extremely life threatening. It is often difficult to identify the exact substance creating the problem. They may all be used interchangeably depending on availability and preference. There are subtle differences in the actions and effects but not enough is known about the differing effects to distinguish them. They can all produce dependence, abuse, and intoxication.

A. Methods of Ingestion:

1. Fabric soaked in the substance held over the nose and inhaled.

2. Vapors released into a bag and then inhaled.

3. Vapors inhaled directly from aerosols or sprayed directly into the mouth or nose.

4. All of the above reach the bloodstream quickly and create intoxication.

B. Diagnosis

1. May present with auditory, visual or tactile hallucinations or other perceptual disturbances. Delusions may have developed during periods of intoxication. Anxiety may be present. Substance abuse may begin with school problems and/or family conflict. Most often inhalants are used by adolescents in a group setting.

2. Dependence has been identified in industrial workers with long-term occupational exposure to inhalants. Use may also occur when substance abusing individuals find themselves in prison, the military, in residential situations, isolated in rural areas and do not have access to their drug of choice.

C. Treatment

No particular treatment methodology has been identified at this time. Treating the general dependency syndrome is advised. If the client is a child, the family should be included in treatment if it does not pose a threat to the child's safety.

8. Nicotine dependence

Nicotine, a highly used substance in tobacco form in America is also used as an effective pesticide. Nicotine is considered to lead to dependence but not to abuse. There appear to be seven major factors crucial in starting and maintaining a tobacco addiction:

- Modeling and ease of access
- Peer pressure
- Physiologic addiction
- Genetic predisposition
- Habit and ritual
- Paradoxical tranquilizing effect of nicotine on the chronic smoker
- Personality needs such as oral eroticism

A. Diagnosis

Very often the nicotine dependent client is self referred, or referred by a physician due to chronic physical ailments. It is also noted that a history of major depression is common in heavy smokers.

B. Treatment

1. Treatment efforts have had limited success and when successful the relapse rate is very high.

2. Support of those around the smoker seems to help.

3. Gradual titrating of the nicotine itself like using nicotine gun or patches helps some.

4. Prevention is more effective than cure.

5. Psychotherapy

   a. The following strategies delivered during therapy seem to help:
      - Increasing delay strategies.
      - Identifying a "quit day."
      - Use of nicotine gum.
      - Hypnosis, autogenic training and/or relaxation training used to develop coping skills.
      - Aversive techniques such as rapid smoking techniques.
      - Attention to diet and exercise.
      - Treatment of any other disorders such as depression or anxiety disorders.
      - Support group.

- Family therapy to facilitate support and eliminate subversive behaviors.
- Behavioral training to cope with stress and avoid high-risk situations.

6. Success in quitting proceeds as follows:

a. Consideration of change
b. Crystallization - realistic expectancies about the annoyances that may arise when they quit.
c. Concrete preparation
    - Learning anti-stress skills such as hypnosis and yoga
    - Contracts with others
d. "Just do it" phase:
    - Smoking is cessated and new behaviors put in place
    - Coping strategies are used to deal with withdrawal
    - Continues for three to six months
    - Often there is weight gain.
e. Maintenance - lifestyle changes put in place.
f. Anti-Relapse - a plan is made ahead of time to avoid behaviors that may lead to relapse.

9. Opioid use disorder

The Opium poppy has been used for at least six thousand years. Abuse increased with the invent of morphine and heroin which creates a warm, sensual euphoria. Tolerance develops rapidly and withdrawal is often within six to twelve hours after a heroin injection. The 1980's saw the rise of cocaine use, the 1990's appears to be the decade of heroine.

A. Diagnosis

The primary distinguishers are opioid dependence, active intoxication or withdrawal. While intoxicated the client may experience sexual dysfunction, suffer hallucinations or delusions and experience sleep disorders. These clients are not usually self referred but are often received via the criminal justice system, the school system, or as a result of other medical complications or a pregnancy.

1. **Initial Information.** It is important to identify:

- How frequently and for how long the drug has been used.
- The day and time of last use.
- Route and amount.
- How much it cost.
- Why it is being used i.e., to get high or relieve other problems.
- Any previous treatment.
- Prescriptions drugs being concurrently used.
- Medical problems.
- Social situations.
- Living arrangements.
- Sexual orientation.
- Employment.
- Family relationships.
- Use of leisure time.

2. Physical Examination

It is important to get a complete physical workup to rule out any organic contributors to the problem. Basic tests to be obtained are:

- Urine
- Blood
- Chest x-ray
- HIV test
- Hepatitis
- Electrocardiogram (40+ years)
- Pregnancy test
- Tuberculin skin test

B. Testing

1. Addiction Severity Index

2. MMPI-2

3. 16 PF

4. WAIS-R

C. Treatment

The highest success appears to include long-term therapy, methadone maintenance and active involvement in a support group. Therapeutic communities have been useful but are often difficult to access. The first step in treatment is detoxification. The ideal, but not the average, detox time frame is 3-6 months.

1. **Detoxification Period** - During the detoxification period the following substances can be used to ease the withdrawal:

   a. Methadone
   b. Naolxone

2. **Withdrawal Period** - After the withdrawal phase the client needs to look toward longer treatment of the underlying problems that led to the addiction. Chemical interventions during this phase can include:

   a. Tranquilizers
   b. Antidepressants

10. Phencyclidine use disorders

The Phencyclidine substances include PCP, Semylan and similarly acting substances such as Ketamine or Ketalar, Ketaject and TEP. They are usually obtained as street drugs and can be taken orally, intravenously or can be smoked. Common street names are PCP, Hog, Tranq, Angel Dust, and Peace Pill. It is believed that withdrawal occurs but it is difficult to identify since it is a very subjective experience.

A. Diagnosis

1. Behavioral Assessment and Physical Examination

Diagnosis is based on behavioral assessment of the changes that take place after ingestion of the substance. Physical perceptions may include horizontal and/or vertical mystagmus, hypertension, tachycardia, diminished pain sensation, ataxia, dysarthria (stammering), muscle rigidity, seizures, and hyperacusis (sound sensitivity). A physical examination should include:

- Blood Screen
- Urine Screen

2. The clinical interview should include:
   - History of use.
   - History of complaints from friends or family members.

B. Treatment

Initial treatment includes protective supervision in a non stimulating environment to protect from self-injury.

1. Belongings should be searched to rule out further substance resources.

2. Vital signs should be monitored.

3. Restraints avoided.

4. Talking-down techniques are helpful during acute hallucinations but should be avoided afterwards because they may intensify agitation.

11. Sedative, hypnotic, or anxiolytic use disorders

Sedatives and hypnotics are commonly prescribed to reduce anxiety and treat insomnia. Benzodiazepenes are commonly known as Xanax, Librium, Klonopin, Tranxene, Valium, ProSom, Mazicon, Dalmane, Paxipam, Ativan, Versed, Serax, Centrax, Doral, Restoril and Halcion. Most people who are not anxious don't find their effects pleasurable. Individuals who become dependent on Benzodiazepenes can be classified into one of three groups:

- Street drug-abusers.
- Alcoholic individuals who are given prescriptions for other problems.
- Patients with depression or panic disorders who are prescribed high-doses for long periods of time.

A. Diagnosis

The clinical interview should identify the source of the drug, street or prescription. Then the distinction of dependence or abuse must be determined. Symptoms such as mood disorders, anxiety disorders, sexual dysfunction and sleep disorders need to be sorted out from the effects of the drug. "Clients who have been diagnosed with depression or panic disorders may have been prescribed high doses of Benzodiazepenes for long periods of time by their treating physician. This does not necessarily equate with a substance disorder or contraindicate benzodiazepine treatment" (Galanter and Kleber, 1994).

B. The Dependence/Withdrawal Cycle

1. This occurs often during long-term treatment of:

a. Generalized anxiety disorder
b. Panic disorder
c. Severe insomnia

2. Process

a. Pre treatment phase - The time before the patient was treated with benzodiazepines.

b. Therapeutic response phase - Side effects such as:
- Drowsiness
- Psychomotor impairment
- Memory impairment may occur.

c. Tolerance develops within a few days and may last within the range of days to years.

- **Symptom escape/dosage escalation phase** - the chosen benzodiazepine may suddenly lose its effectiveness. It may coincide with increased life stress or not. Dosage may be increased or drug substitution made. Those with the above interventions are at greater risk for protracted withdrawal symptoms.

- **Withdrawal phase** - when the daily dose falls below 25% of peak maintenance and the patient becomes increasingly symptomatic. There may even be an emergence of new symptoms.

- **Resolution phase** - following symptom rebound and a period of abstinence lasting months to over a year. Symptoms will vary in intensity from day to day. Those who can remain drug free for over 5 weeks show lower levels of anxiety than before discontinuation.

12. Polysubstance abuse

A. Diagnosis

1. Identification

a. When a person has used at least three different substances (not including caffeine or nicotine) for at least six months and no substance has reached dominance.
b. There is often a seeking for solutions to problems outside of self or a seeking for external stimulation.
c. Polysubstance abusers often appear to be more deeply disturbed than other monosubstance identified individuals.
d. Often late adolescence or young adults.

2. Testing

- MMPI-2
- 16 PF
- MCMI-III

B. Treatment

1. **Detoxification** can include acute withdrawal reactions. The standard stabilization sequence requires:

    a. The use of oxygen to stabilize respiration
    b. Inderal for any cardiac arrhythmia's
    c. A barbiturate to reduce CNS stimulation
    d. Benzodiazepines to control convulsive reactions.
    e. These responses are short-term and need to be carefully monitored to avoid secondary abuse behaviors like solicitation of more drugs from peers to ameliorate the withdrawal symptoms.

2. **Psychotherapy**

    a. Group treatment that emphasizes confrontation
    b. Rational-emotive or reality therapy

3. **Family therapy**

C. Treatment

1. **Withdrawal**

    a. The clinical picture is often similar to withdrawal from barbiturates and might include:
        - Anxiety
        - Tremors
        - Nightmares
        - Insomnia
        - Anorexia
        - Nausea
        - Vomiting
        - Postural hypotension
        - Seizures
        - Delirium
        - Hyperpyrexia (increased body temperature)
    b. The course of treatment depends on the drug of abuse.

2. **Symptom rebound**

    There may be symptom rebound when the drug is removed or an intensified return of the symptoms the drug was prescribed for. Rebound lasts a few days to weeks.

3. **Protracted withdrawal** from benzodiazepines

    a. Symptoms consist of relatively mild symptoms such as:
        - Irritability
        - Anxiety
        - Insomnia
        - Mood instability

b. These symptoms can be severe and disabling and last many months. Some have described the process as mimicking an obsessive-compulsive disorder with psychotic features. Other symptoms might include:
   - Increased sensitivity to sound
   - Light
   - Touch
   - Paresthesias

4. **Recrudescence** - Symptom reemergence differs from symptom rebound in that it implies that the original symptoms have not been adequately treated.

13. Other substance-related disorders

Includes the use of Anabolic Steroids, Nitrite inhalants, Nitrous oxide and the abuse of prescription drugs.

A. Prescription Drug Abuse

Rather than differentiate between the substances the method of obtaining the substance is addressed. The trend has been away from the barbiturates of the past which were abused to amphetamines and minor tranquilizers that are heavily abused currently. The abuse tends to emerge in individuals between the ages of 30 and 60 in middle-class and upper-class females. They generally consume prescribed tranquilizers for nervous complaints or insomnia and gradually increase the dosage often layering an increase in the use of alcohol. The abuse is often not detected since 90% of the substances are prescribed by physicians who have no special training in psychological disorders. Common signs of abuse are:

- Efforts toward making sure prescriptions are filled quickly.
- Developing backup prescriptions or physician contacts.
- Resistance-avoidance toward any health care professional who begins to confront the pattern.
- Increased contacts with sympathetic health care workers.
- Depression and anxiety increase when prescription refills are delayed or renewals are threatened.
- Withdrawal from standard interests, friends or activities.
- Increased use of alcohol to supplement the pill's effects.

B. Treatment

1. Since a high percentage of the abusers have a middle-class value system hospitalization for detoxification is well accepted. The initial stage includes tension and depression. Relaxation training is helpful. Helping the individual identify areas in their lives in which they have control increases self-efficacy.

2. Assertiveness training.

3. Expansion of social networks and exacerbating problems such as insomnia and obesity also need to be addressed in treatment.

CHAPTER 10

Psychopharmacology

Psychopharmacology is an area of knowledge that is important to today's counselor. Drugs have helped relieve the use of hospital beds previously occupied by the chronically mentally ill. We still only partly understand why drugs work, and the research and use continues. The counselor's consideration of psychopharmacological intervention needs to come from an informed perspective rather than an across the board belief that drugs are good or bad. The things you need to consider with medication are:

To what extent is this problem due to psychological factors and to what extent is it due to a biochemical disturbance? (Preston and Johnson, 1992)

In the service of this question the first intervention is a current physical exam or a contract with the client to have one. After this question has been answered the next questions to consider follow.

What do you do when you take in a new client who is currently on medication?

It is important you understand how prescription medication and street drugs affect your client. It would be a good idea to obtain the name of the prescribing physician/s and obtain releases to verify the type and dose of each medication the client is taking. Then, you need to do your homework so you understand each medication.

What do you do when you believe a client might benefit from medication?

You need to discuss the possibility with your client from an informed perspective. There are several diagnosis that have treatment protocols that include the possibility of psychopharmacology.

They include:
- Schizophrenia
- Depression
- Bi-polar
- Anxiety
- Attention Deficit Disorder

Then, if the client agrees, direct him/her to consult with his/her current physician for medication or a referral to a psychopharm specialist. If the client does not have a physician it is important you have a physician you can refer to who is knowledgeable in the areas of psychopharmacology.

What do you need to know about medication?

You need only be familiar with the general categories of drugs used in treatment. In order to understand a drug it is recommended you understand:

- Type of drug
- Indications - when it may be helpful
- Action or Course
- Tolerance
- Dependency
- Side Effects
- Precautions
- Withdrawal

Remember, when you see your client ask yourself the following:

- Is this client currently on medication?
- What do I know about the medication and its effects?
- Have I obtained a release so I can obtain further information from their physician?
- Could this client benefit from psychopharmacological intervention?
- Has this client been advised of this resource?
- If the client is on or chooses to use psychopharm, what information do I need to inform them of?

IMPORTANT CONCEPTS

1. Action

Pharmacokinetics

Psychoactive drugs interact with the Central Nervous System (CNS) and produce changes in mood, consciousness, perception and often times, behavior. In order to affect users, psychoactive drugs need to be in a sufficient dosage to create an effect. This concentration can be determined by how much is taken, as well as how the drug is "distributed." This distribution process is referred to as the drug's "pharmacokinetics" which includes:

- Absorption
- Distribution
- Transformation by metabolism
- Excretion

Pharmacodynamics

The term "pharmacodynamics" refers to the process involved in how the drug begins its effects at its particular action site in the CNS, i.e., neurotransmitter substances such as norepinephrine, serotonin or dopamine.

2. Drug tolerance

Tolerance is a reduced response to a drug as the result of repetitive use. The body becomes increasingly effective at eliminating the drug or the receptor cells become less sensitive to the drug because of repeated exposure. This drives the need for an increase in dosage to maintain the same objective or subjective experience.

Marked Tolerance
Substance abuse occurs when the maladaptive behavior pattern caused by substance use does not meet the criteria for a diagnosis of "Substance Dependence" but does involve continued use of the drug despite knowledge of its negative impact on social, occupational, psychological, or physical conditions and/or recurrent use of the drug in physically hazardous situations.

3. Dependence or addiction

A compulsive need to use a drug to experience its effects or avoid the discomfort that occurs when the drug is reduced or eliminated.

A. Physical

Physical dependence can result from a drug tolerance reaction. Biochemical changes occur in the body.

B. Psychological

A powerful drive to experience the effects of the drug such as euphoria, an altered state of consciousness, or a reduction in anxiety. For more detail refer to the chapter on Substance Abuse.

4. Precautions

A. Synergism

Individual drug effects can be changed with the addition of other substances such as other drugs, foods or hormones. Some substances will increase a drugs effect while others will reduce the drugs effect. The term "synergistic" refers to the increase of the effect of a substance combination such as alcohol and other sedative or hypnotic drugs.

B. Withdrawal

The dynamics of withdrawal are drug specific. It does not necessarily follow that it is easier to withdraw from a psychological addiction than a physical addiction.

PSYCHIATRIC DRUGS

In the following categories of drugs you will find specific drugs listed. They are examples and not necessarily a comprehensive list in each area.

1. Antipsychotics major tranquilizers and neuroleptics

Psychosis is not an illness it is a symptom indicating impaired reality testing. Research supports the theory that antipsychotics work by blocking dopamine receptors in the brain. Since schizophrenia is thought to be related to overactivity of dopamine receptors it is one of the syndromes treated with antipsychotics. Other diagnosis often treated with antipsychotics are:
- Psychotic mood disorders
- Mania and depression
- Psychosis associated with neurological conditions such as Alzheimers and head injuries.

These agents reduce or eliminate delusions and hallucinations, reduces affective tension and psychomotor agitation, augment activity and restore contact with reality. There are many ways a client can have impaired reality testing or loss of contact with reality such as:
- Confusion
- Delusions
- Hallucinations
- Impairment in judgment and reasoning

When psychosis is present it is generally a good idea to make a referral for psychiatric consultation.

A. Types

Phenothiazines
  Thorazine - Chlorpromazine
  Mellaril - Thioridazine
  Stelazine - Trifluoperazone
  Serentil - Mesoridazine
  Prolixin - Fluphenazine

Thioxanthenes
  Navane - Thiothixene

Butyrophenones
  Haldol - Haloperidol

Dibenzazepine
  Loxitane - Loxapine
  Clozapine - Clozaril (blood needs to be drawn weekly)
  Zaproxyl

Dihydroindolone
  Moban - Molindone

B. Indications

Anorexia
Agitation
Assaultive behavior
Blunted affect
Bizarre thinking
Catatonic behavior
Confusion
Delusional thinking
Depression
Disorientation
Hallucinations
Insomnia
Mania
Memory loss
Paranoid thinking
Psychomotor agitation
Social withdrawal
Thought withdrawal

C. Course

These drugs are usually effective in two stages:

First stage
The patient is sedated but remains afflicted with psychotic symptoms

Second stage
The patient loses their delusional and hallucinatory symptoms and can go to a lower maintenance dose

D. Dependency

Anti-psychotics are thought to not be addictive or become tolerated either psychologically or physically.

E. Side Effects

1. Anticholinergic (autonomic)

Dry mouth
Blurred vision
Tachycardia
Urinary retention
Constipation

Appear early and tolerance ordinarily develops within a few weeks or months. Elderly patients are most susceptible.

2. Orthostatic Hypotension

- Abnormally low blood pressure when standing
- Tolerance usually within the first several weeks of drug use
- Sedation

Can be tolerable if client is agitated or aggressive. Tolerance usually develops within several days or weeks.

3. Extrapyramidal Effects

- Akathasia - a sense of inner restlessness.
- Motor restlessness
- Dystonia - lack of muscle tone
- Muscle spasms in mouth, face and neck
- Parkinsonism - tremor, face expressionless, speech slow, muscular rigidity, head bowed, small quick shuffling steps
- Tardive dyskinesia - most serious. Symptoms are often irreversible unless recognized early and treatment is stopped. Involuntary rhythmic movements of the jaw, lips, tongue and extremities.

4. Other

- Jaundice
- Blood dyscrasias
- Skin rashes
- Higher sun sensitivity, may burn more easily
- Amenorrhea
- Infertility
- Impotence
- Increased appetite and weight gain
- Insomnia
- Depression
- Lowered seizure threshold

F. Precautions

These drugs can cross the placental barrier and produce birth defects or side effects in the newborn. A 30-60 day supply of antipsychotics taken all at once can be fatal when consumed with a CNS depressant.

G. Symptoms

- Hypotension, dizziness
- Severe urinary retention
- Seizures
- Sore throat during first several months of treatment
- All of the above sometimes referred to as "neuroleptic malignancy."

H. Withdrawal

- Abrupt withdrawal may cause:
- Insomnia
- Nightmares
- Sleep disturbances
- Cholinergic rebound such as abdominal cramps, diarrhea, increased salivation

2. Minor tranquilizers or anti-anxiety agents - anxiolytics

First introduced in the 1950's as an alternative to barbiturates for relieving anxiety, they are effective in treating anxiety, tension and psychosomatic disorders. They have also been used to control alcoholism, epilepsy, and phobic states. When you are considering the diagnosis of anxiety the following questions need to be answered before making the referral for a psychopharm assessment:

- Is this a generalized anxiety disorder?
- Is this anxiety stress related?
- Is this a panic disorder?
- Is this a social phobia?
- Is a medical illness present with anxiety symptoms?
- Are the anxiety symptoms part of a primary mental disorder such as depression or schizophrenia?
- Is the anxiety being caused by some other substance?

A. Types

1. Propanedios

Miltown/Equanil - Meprobamate

2. Benzodiazepines

Valium - Diazepam
Librium - Chlordiazepoxide
Xanax - Alprazolam
Serax - Oxazepam
Dalmane - Flurazepam
Ativan - Lorazepam

3. Non-Benzodiazepine

BuSpar - Buspirone

4. Beta-Blockers

Inderal - Propanolol

5. Anti-convulsants

Tegretol
Klonopin - Clonazepam

B. Clinical Indications

Used for exogenous (outer) anticipatory anxiety, but not if the endogenous (inner) anxiety from panic attacks is the sole factor.

GAD - Generalized Anxiety Disorder
Panic Disorder
Phobic Disorders
OCD - Obsessive-Compulsive Disorder
PTSD - Post Traumatic Stress Disorder
Tobacco abuse
Depression
Withdrawal
Headache
Chills nausea
Vomiting
Anxiety
Irritability
Motor Restlessness

C. Action

These drugs mediate the actions of GABA, the brain's major inhibitory neurotransmitter. They are most effective on a time-limited basis since they have been found to produce similar adverse side effects, withdrawal symptoms and patterns of abuse similar to the barbiturates. Actions arise in 15-40 minutes and effects can be determined after 1-2 doses.

D. Dependence

The relaxation, euphoria and sense of well-being promotes psychological dependence. Chronic use can create physical tolerance and dependency.

E. Side effects

Drowsiness
Lethargy
Ataxia (loss of muscle coordination)

F. Precautions

These drugs should not be consumed with other CNS depressants. Excessive coffee use can counteract the effects.

G. Withdrawal

Anxiety
Agitation
Insomnia
Anorexia
Muscle cramping
Tinnitus

Blurred vision
Headaches
Hypotension
Hypothermia
Psychosis
Seizures

3. Antidepressants - used to relieve depression

When you have considered the diagnosis of depression it is important to distinguish between:

- Reactive sadness
- Grief
- Medical illness and any medication that may be causing depressive symptoms
- Clinical depression (Preston and Johnson, 1992)

If the clinical determination is clinical depression psychopharmacological interventions may be appropriate if the symptoms have been sustained.

A. Types

Antidepressants are divided into three types:

1. Tricyclic (TCA)
2. Tetracyclic (HCA)
3. Monoamine-Oxidase Inhibitors (MAOIs)

B. Indications

Major depression
Chronic pain
Anorexia nervosa
Bulimia
Pseudodementia
Agoraphobia
Attention deficit hyperactivity disorder
Atypical depression
Borderline personality disorder
Dysthymic disorder
OBD
Schizoaffective disorders
Treatment resistant depression

C. Action

TCA's usually require 10-14 days to start working, full effect in apx. 6 weeks

D. Dependency

Not thought to create dependency.

E. Side Effects

Anticholinergic (interferes with the action of acetylcholine in the brain)
Blurred Vision
Dry Mouth
Sweating
Constipation
Urinary Retention
Orthostatic Hypotension
Tachycardia
Palpitations
Hypertension
Confusion
Skin rashes
Paresthesias (feels like bugs are crawling on the body)
Blood Dyscrasias
Nausea
Vomiting
Weight gain
Changes in libido
Paradoxical agitation or depression
Lowered seizure threshold
Insomnia
Disorientation
Sedation

F. Precautions

When starting, clients should be careful driving cars, working around machines, and crossing streets, since reflexes may be off.

Ataxia
Drowsiness
Delirium
Cardiac arhythmia's
Seizures
Coma

G. Withdrawal

Suddenly stopping TCA's can trigger nausea, bad dreams, altered heart beat, and cold in 2-4 days. For withdrawal, dosage should be titrated off.

H. Types Expanded

1. Tricyclics TCA

Sinequan - Doxepin
Tofranil - Imipramine

Elavil - Amitriptyline
Desipramine - Norpramin

Most often used for the treatment of depression. Elevate mood and increase overall activity, increase appetite and improve sleep patterns. Good for endogenous depression rather than an exogenous or reactive depression. Since they take 2-4 weeks to take effect ECT is sometimes recommended for clients with severe depression who are a high suicide risk.

2. Tetracyclics

Thought to be more effective than the Tricyclics they are similar in terms of their therapeutic action and side effects.

- Monocyclic
- Bicyclic

Thought to have fewer side effects than any of the other drugs. Often identified as Selective Serotonin Receptacle Inhibitors (SSRIs):

Prozac - Fluoxetine
Paxil - Paroxetine
Zoloft - Sertraline

3. MAO Inhibitors

Most effective for treating atypical depression. The MAO's create their effects by inhibiting the enzyme monoamine oxidase which is involved in the deactivation of epinephrine, norepinephrine, serotonin, and a number of other neurotransmitters and body chemicals. Serious hypertensive crisis can occur when taken in conjunction with barbiturates.

Nardil - Phenelzine
Parnate - Tranylcypromine

4. Mood stabilizers

A. Types: Lithium

B. Indications

Lithium is the drug of choice for the treatment of mania. It is also used for:

- Bipolar disorder
- Unipolar depression
- Schizoaffective episodes
- Emotionally unstable character disorder
- Borderline
- Premenstrual dysphoria
- Alcoholism

C. Action

Its therapeutic effects often do not occur until 7 to 10 days after the first dose.

D. Dependence - is not found to create dependence.

E. Side Effects

Muscle Weakness
Tremors Of The Hand
Fatigue
Nausea
Vomiting
Diarrhea
Weight Gain
Polydipsia
Precautions
Coarse Tremor
Severe Lethargy
Slurred Speech
Ataxia
Confusion
Convulsions
Coma

F. Precautions

Lithium affects the renal system and needs to be closely watched with blood testing to obtain an optimal dosage that does not begin to degrade the renal function.

5. Sedatives-hypnotics

A. Types

Benzodiazepines
Barbiturates
Barbiturate like hypnotics
Non-Benzodiazepines

B. Indications

Cataplexy (sudden loss of postural tone)
Narcolepsy (sudden sleep)
Night terrors
Sleep apnea
Sleepwalking

C. Action

Generally act as CNS depressants and are dose dependent. Low dose - reduces arousal and motor activity. Large dose - induces sedation and sleep.

D. Dependence

Chronic use results in tolerance, psychological dependence and physical dependence.

E. Precautions

A small amount of alcohol with a modest dose of barbiturates can have lethal consequences.

F. Withdrawal

Abrupt withdrawal causes:
Tremors
Anxiety
Nausea
Vomiting
Paranoia
Hallucinations
Delirium
Life threatening convulsive seizures

1. Barbiturates

Introduced in the early 1900's for sleep and relaxation their use has been expanded and their addiction potential identified.

A. Types

Amytal - Amobarbital
Nembutal - Pentobarbital
Seconal - Secobarbital
Luminal - Phenobarbital

B. Indications

Insomnia

C. Dependency

High likelihood of tolerance, psychological dependence and physical dependence.

D. Side effects

Slurred speech
Dizziness
Irritability
Impaired motor movement
Cross the placental barrier and can produce birth defects or congenital dependency
Can cause a decrease in REM sleep and nightmares

E. Precautions

Are an abused class of drugs for:

1. Middle and upper class individuals who obtain prescriptions for insomnia or anxiety.
2. Adolescents who obtain the drug illegally and use it for recreation.
3. Abusers of amphetamines, cocaine, alcohol and other drugs who use barbiturates to counteract the negative effects of those drugs.

F. Dangers

Barbiturates are frequently involved in suicide and accidental death when mixed with alcohol or other drugs. Since the respiratory centers do not adapt to the drugs effects and other systems might, the user might not know when they are taking a lethal dose.

G. Overdose Symptoms

Ataxia
Confusion
Agitation
Disorientation
Cold/clammy skin
Dilated pupils
Respiratory depression
Death

H. Withdrawal

Generally severe and can be life-threatening. Recommend 10% dose reduction at a time.

6. Ethyl alcohol

Once widely used medicinally as an analgesic, anesthetic and tranquilizer, its medical use has virtually ceased due to the development of more effective drugs.

Alcohol is the most frequently self-administered and widely abused legal drug in our culture.

7. Opioid-analgesics

A. Types

1. **Natural** - Derived from the opium poppy the natural opioids are:

Opium
Morphine
Codeine

2. **Semisynthetic** derivatives of morphine

   Heroin
   Percodan
   Dilaudid

3. **Pure synthetics**

   Demerol
   Darvon
   Methadone

B. Indications

Medically the opioid-narcotics are used for the same reasons that opium was used centuries ago for the treatment of diarrhea, as a cough suppressant, and as an analgesic.

C. Action

Have both sedative and analgesic effects.

D. Dependency

Chronic use results in tolerance, psychological dependence and physical dependence.

E. Side Effects

Constricted pupils
Decreased visual acuity
Increased perspiration
Constipation
Nausea
Vomiting
Respiratory depression
Crosses the placental barrier and can cause congenital dependency

F. Precautions

Slow and shallow breathing
Muscle rigidity
Catalepsy
Clammy skin
Decreased blood pressure and pulse rate
Convulsions
Coma
Death from respiratory failure

G. Withdrawal

Stomach cramps
Nausea

Vomiting
Weakness
Fever
Muscle and joint pain
Sweating
Mild hypertension
Insomnia
Methadone is used for heroin withdrawal

8. CNS Central Nervous System Stimulants

Although abused illegally, stimulants can be used to treat:

ADHD Attention Deficit Hyperactivity Disorder
Treatment resistant depression
Narcolepsy
AIDS

TYPES

1. Amphetamines

Amphetamines exert their effects by stimulating the release of norepinephrine, dopamine, and serotonin in the brain. They are referred to as sympathomimetics because they mimic the actions of the sympathetic nervous system. Amphetamines decrease fatigue, enhance physical and mental performance, stimulate talkativeness, elevate mood, excite tremors, decrease appetite, dry the mouth, increase perspiration, dilate pupils, and create bruxism. Available in the 1930's as prescription drugs, they have been used to treat narcolepsy, depression, petit mal epilepsy, obesity, brain damage and hyperactivity in children.

A. Dependency

Not believed to result in physical dependence long-term use can result in tolerance and psychological dependence.

They are highly abused both in prescription form and on the street as methadrine or speed.

B. Side effects

Nausea
Vomiting
Irritability
Headache
Palpitations
Dizziness
Anxiety
Apprehension
Confusion
Dysphoria

C. Precautions

Prolonged use can cause psychosis and is characterized by hostility, aggression, hallucinations, delusions of persecution, cardiac arrhythmia's, diarrhea and abdominal cramps. Symptoms can become chronic.

2. Methylphenidate

Better known as Ritalin, is a derivative of amphetamine but less powerful. Used to treat epilepsy, obesity, depression and narcolepsy. Currently being used to treat attention deficit hyperactivity disorder.

A. Side effects

Anorexia
Insomnia

B. Dependency

Not believed to create dependency

3. Cocaine

Made from the leaves of the coca plant, cocaine is a potent local anesthetic and central nervous system stimulant. Effects include feelings of euphoria, excitation, restlessness, perceptions of increased strength and mental abilities. Freud used cocaine as a cure for heroine addiction.

A. Side effects

Dilated pupils
Tachycardia
Decreased appetite

B. Precautions

Can mirror amphetamine psychosis and paranoid schizophrenia
Hypervigilence
Agitation
Impaired judgment
Paranoia
Severe depression
Visual and tactile hallucinations
Serious overdose can cause convulsions, coma and death

C. Dependency

May lead to psychological dependence. May produce "reverse" tolerance.

BEST COPY AVAILABLE

D. Use

May be taken intra nasally (snorted) and can also be injected intravenously or smoked in a purified alkalinized form (free-basing). First experience is a "rush," when it is smoked or injected the effect is more immediate. The effect is short lived followed by dysphoria and a craving for more cocaine. Because of the craving, and cost of the drug, cocaine can create serious emotional, financial and social problems.

E. Withdrawal

Fatigue
Nausea
Hunger
Chills
Tremor
Severe depression

9. Hallucinogens and cannabis

A. Hallucinogens

Heighten sensory awareness, perceptual distortions, emotional lability and alterations in thinking.

1. LSD

Altered perceptions are the major experiences of LSD. The psychological effects depend on the dosage, purity as well as the personality and expectations of the user. There is also impact from the environment such as location and those one takes the drug with.

a. Precautions

Bad trip
Delirium
Depersonalization
Psychosis
Flashbacks

b. Dependency

Not thought to be physically or psychologically dependent.

c. Withdrawal

None

2. PCP - Angel Dust

Originally used as an animal tranquilizer and human anesthetic. No longer produced in the US, it still seems to be available. PCP is one of the most dangerous hallucinogens and is associated with assaultiveness, paranoia, psychomotor agitation, ataxia, muscle rigidity, nystagmus, slurred speech, vomiting, convulsions, respiration depression, hypertensive crisis, seizures, coma and death.

B. Cannabis

Archaeological data suggests that cannabis has been used for medical, religious and recreational purposes for at least 6,000 years.

Today it is sold illegally as marijuana and hashish. The psychoactive ingredient is THC tetrahydrocannabinoth. Usually smoked and can be eaten. Medically it is used to alleviate nausea and vomiting and for glaucoma, reducing intra ocular pressure.

The effects are dose dependent. Psychologically the effects usually include mild euphoria, relaxation, an altered sense of time, heightened sensory awareness, giddiness, food cravings, slowed thought processes, and impaired short-term memory and concentration. Physically it increases blood pressure and heart rate, dry mouth and lowers body temperature.

1. Dependence

Long term use can lead to psychological and physical dependence.

2. Side effects

a. Panic
b. Anxiety
c. Paranoia
d. Social withdrawal
e. Dysphoria
f. Depersonalization
g. Hallucinations
h. Flashbacks
i. Chronic use can create "amotivational syndrome" which is indicated by:
  - Apathy
  - Listlessness
  - Decreased attention span
  - Lower motivation
  - Poor judgment
  - May possibly decrease testosterone levels, sperm count, and cause birth defects.

3. Withdrawal

a. Restlessness
b. Irritability
c. Loss of sleep
d. Anorexia
e. Diarrhea
f. Weight loss
g. Hyperactivity tremor
h. Tremor

PROFESSIONAL/CLINICAL ISSUES

A. Clinical Assessment

When doing a clinical assessment for psychopharacology, always ask:

1. Is there a biological clinical component identified by the DSM-IV?
2. Has there been a history of drug use, legal or illegal?
3. Is there a potential for abuse or suicide?
4. Is the client outpatient or inpatient?
5. Does the medication need close monitoring?
6. How does the client feel about using medication?
7. Is there a biological component identified by treatment guidelines?

B. Treatment Planning

Treatment planning needs to be done with a knowledge of the effects of the medication and course of treatment. There should be an exchange of information between the prescribing physician and the treating therapist about any change in the client's condition.

C. Referral To Professionals

Have the client check with their current primary physician for treatment or referral. In the absence of a personal physician have a physician you have a working relationship with, to whom you can refer your clients'.

D. Patient Education

1. Clients should know their diagnosis unless there is a clinical reason this would be contraindicated.
2. The target symptoms and what the drug is supposed to reduce.
3. The length of time they will be on the drug.
4. Both expected and possible adverse effects.
5. The treatment plan to be followed if the drug is unsuccessful.

If you do not believe the client can comprehend this information, tell them anyway in as clear a way as possible. If they have a caretaker, with a release if needed, provide this information. Document this has been done.

CHAPTER 11

Research and Evaluation

RESEARCH DESIGN

Research is the empirical, systematic investigation of the relationship between two or more variables in a controlled way. The purpose of research is to conclude that variation in the dependent variable is caused by variation in the independent variable and to answer a question in a controlled, systematic format.

1. The research process

The research process begins with identifying the question to be studied as clearly as possible, and a tentative hypothesis established. The background of the problem is then considered and explored, including a review of the relevant literature. The variables are defined and a research strategy is selected. The study is then conducted, and the results are analyzed, conclusions are reached and the research findings are reported.

2. A research design

A research design is necessary for research to be systematic. The research design must be based on a plan specifying (1) a general research strategy, (2) designation of the population of interest, (3) the method to be used to select the sample from the population, (4) nature of the variables to be studied, (5) conditions under which the study will be conducted.

A. Variable

A variable is any aspect of a person, group, or setting that is measured for the purposes of the study in question. Variables are any phenomenon or characteristic capable of variation, or of existing in at least two different states, conditions, or levels.

1. Variables come in two forms: independent variables and dependent variables. Independent variables are believed to be the cause of change or variation in a dependent variable. Variation in dependent variables "depends on" variation in an independent variable. Independent variables are the characteristics or phenomena to be controlled while the dependent variables are the characteristics or phenomena to be tested for. Consider the following statements:

   a. What is the effect of (independent variable) on (dependent variable)?
   b. If . . . (independent variable), then . . . (dependent variable).

2. A continuous variable is a variable which is potentially able to take on any value within a continuous range of values, ex: age, height, temperature.

3. A discrete variable is a variable that can assume only certain values, ex: political party, DSM-IV categories, Beck Depression Scale.

B. Sampling

Sampling is the method used to select subjects from the population of interest (since often the entire population cannot be studied).

1. Simple Random Sampling: Before a sample will adequately serve as a basis for making estimates of population parameters, it must be representative of the population in all respects. Use of a Table of Random Numbers is the simplest method of drawing a random sample. It is a computer-generated list found at the back of most statistics books. Using this form of selecting a sample from a population, every member of the population has an equal probability of being selected for inclusion in the sample.

2. Stratified Random Sampling can also be used where the population is divided into appropriate strata (ex: gender, age, education level). Subjects are randomly selected from each stratum.

C. **An hypothesis** is a statement relating to the study that is to be proved or an idea that has been formulated so that it may be evaluated using scientific methods. It is an "educated guess" that states a predicted relationship between events or variables. It is generally stated: "If A exists, then B will occur."

D. **A research strategy** is the "plan of action". Conducting an experiment means systematically varying one or more conditions for some groups, but not for others.

E. **The study** is to be carried out objectively enough to permit others to replicate it. All steps in the research process must be specified.

F. **An analysis of the results** considers the likelihood that the findings are simply due to chance. The research results include making a distribution of the scores obtained by the subjects; calculating relevant descriptive statistics (describing certain aspects of the subject's performance, i.e., the mean or average); and calculating inferential statistics (used for judgments about the probability that the results are due to chance).

G. **Reporting the research findings** communicates ideas and findings to others and forces the researcher to think through all that has been done and the meaning attached to it. It is an important aspect of the research.

3. Two kinds of research are generally conducted:

A. **Applied research** is done in a naturalistic setting. This research is conducted to answer a certain question in which the investigator is interested and the results have immediate application.

B. **Basic research** is done in a rigorously controlled setting and is pursued without regard to the immediate applicability. This research focuses on theoretical rigor and control.

4. Several research strategies are possible

A. **Experimental research** is characterized by "experimental control". The investigator controls (manipulates or changes) certain independent variables and randomly assigns subjects to treatment groups. The investigator has tight control of the variables to make generalizations to other larger groups (populations) which are similar in important characteristics to the group being studied (sample). Experimental research is conducted to conclude that variation in a dependent variable is caused by variation in the independent variable. The hypothesis would state that variation in the dependent variable is caused by variation in the independent variable.

B. **In Quasi-Experimental research,** the researcher cannot control the levels of the independent variable and/or the assignment of subjects to treatment groups. With quasi-experimental research it is not possible to rigorously follow the experimental approach. The study is set up to resemble the experimental approach, recognizing that the results and the ability to generalize the findings are limited.

C. **Ex-Post Facto research** or "after the fact" research design is where the independent variable is not manipulated by the researcher because the change has already taken place. The experimental treatment is applied and/or the dependent variable data is collected prior to onset of the study. An Ex-Post Facto design cannot be classified as experimental research because no manipulation or control of the variables has taken place.

D. **The purpose of Descriptive research** is to describe "what is", what the existing state of affairs is in whatever area one is examining. No cause and effect explanations are inferred in descriptive research. It is often used as background material for more controlled investigations. Examples of descriptive research are: case studies, surveys, developmental research, correlational studies.

E. **Historical research** reconstructs and examines past events to arrive at conclusions. This kind of research is frequently done to show how previous experience may contribute to understanding of present or future circumstances. Historical research lacks control over manipulation and measurement of variables. There is little control over sampling and no possibility of replication.

5. There are several threats to the validity of a research study. Research can be subject to contamination through:

A. **Internal contaminators** including the personal rigidity of the researcher

B. **Internal/external contaminators** including social desirability, faulty definition, investigator influence or faulty interpretation

C. **External contaminators** such as sampling bias, inappropriate design and questionable instrumentation

6. Group research designs include:

A. One-Group Design

Administration of a single level of an independent variable to one group of Subjects (S's) - an example is a pre-test-post-test design. The researcher administers one form of an academic test to all children in one classroom. The teacher then introduces a 5-minute exercise period every hour during a six week period. The researcher then administers a second form of the same test. The researcher assesses the effects of the exercise period by comparing scores on the two forms of the academic test.

B. Two-Group Design

Administration of one level of an independent variable to one group of S's and another level to the other group. When one group receives some level of the independent variable, it is called the "experimental group"; when a group receives no treatment or a contrast treatment, it is called the "control group". For example, a researcher administers a pretest to the identified hyperactive children in the school. Half the hyperactive children are then given Ritalin (the experimental group) for a period of time while the other half do not receive any drug (the control group). Post-tests are then given to all the hyperactive children. The researcher assesses the effects of the Ritalin by comparing the posttest scores of both groups.

C. More Than Two-Group Design

One or two groups of S's are assessed on one or two levels of a single independent variable. The researcher in the one-group design example could expand the design by including three levels of the independent variable i.e., 1) exercise 5 minute period with no teacher involvement, 2) teacher-administered 5 minute exercise period, and 3) no exercise period. The researcher would randomly assign subjects to one of the three groups, administer a pretest to subjects in all groups, tell one group to watch the clock and on the hour to get up, go to the back of the room and exercise (quietly) for 5 minutes, tell the teacher to have her group go into the hall for 5 minutes for exercise and have the other group continue working. The post-test would then be administered and results assessed.

D. Repeated measures design

A dependent variable is administered to the same S's on more than one occasion, for example:

1. Each S receives one treatment but two or more administrations of the dependent variable, e.g., pre-test - post-test designs
2. Each S receives two or more treatments and two or more administrations of the dependent variable e.g.: a counterbalanced design where several groups each receive treatments (ex: different amount of exercise time) in a different order.

7. Single-subject research designs use repeated measures of the dependent variable throughout the baseline and treatment phases of the study.

A. AB Design

Compares S's status on the dependent variable during two phases. The researcher gives a test for anxiety several times during both Phase A (baseline - no treatment given) and Phase B (treatment given). Phase A and B are compared.

B. ABAB Design

AB design is expanded to include more than one baseline (Phase A) and treatment phase (Phase B).

C. Multiple Baseline Design

Does not require the withdrawal of treatment as ABAB design might. It involves sequential treatments given, with more than one baseline for each behavior with:

1. different behaviors of the same subject

2. the same S in different settings or conditions

3. the same behavior of different S's

CHAPTER 12

Statistics

TYPES OF STATISTICS

There are two types of statistics: Descriptive Statistics and Inferential Statistics. Descriptive statistics involves tabulating, depicting, and describing collections of data. It is a tool for describing, summarizing or reducing to comprehensible form the properties of an otherwise unwieldy mass of data. Inferential statistics predicts or estimates characteristics of a population from a knowledge of the characteristics of only a sample of the population. Statistical methods assist researchers in describing data, in drawing inferences to larger bodies of data, and in studying casual relationships. The choice of a particular method depends, in part, on the type of data collected and in part, on what information is needed from the data and to what use it will be put.

1. Descriptive statistics

Descriptive Statistics are used to describe an entire set of data or distribution of data or a single observation in that set of data. An entire set of data can be described in tables, graphs, measures of central tendency or measures of dispersion. An individual observation in a set of data can be described in relation to the entire set by converting the individual score into a type of transformed score such as a percentile, rank or *z*-score.

A. Scales of Measurement

When data is collected in research studies, it is quantified by using one of four scales of measurement: nominal, ordinal, interval or ratio. Each scale differs in the amount of information it provides and the type of mathematical operations which can be used with it. The level of measurement limits the applicability and interpretation of certain statistical measures and methods.

1. **The Nominal Scale** is considered the most primitive level of measurement. The categories are unordered, mutually exclusive and exhaustive and do not reflect differences in magnitude, merely distinguishes groups. Examples: sex, political affiliation; eye color; DSM-IV diagnosis.

2. **The Ordinal Scale** places observations into categories which provide information about ordering. The information is ranked from greatest to least and is used when data is categorized on the basis of rank order. It does not provide information about the magnitude of the intervals between categories, because the intervals cannot be assumed to be the same distance apart, for example: first, second, third; a questionnaire which asks for "agree", "disagree", or "strongly agree" with a statement; high/moderate/low. When data is categorized on the basis of rank order, 1st, 2nd, 3rd, an ordinal scale of measurement is being used.

3. **The Interval Scale** can equate the magnitude of intervals between successive points on a scale. It allows comparison statements to be made between individuals or things being measured. The zero point on the scale is arbitrary and does not correspond to total absence of the characteristic being measured. Examples of interval scales include: class grades; family income less than $5,000, $5,000 - $9,999, $10,000 - $13,999, etc.

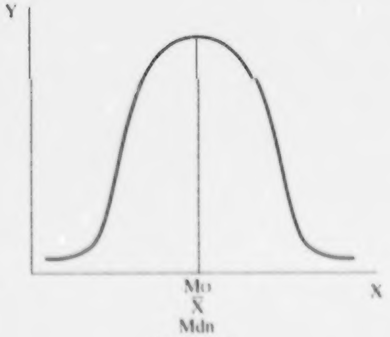
4. **The Ratio Scale** is identical to the interval scale but also has an absolute zero point. Zero indicates the complete absence of the trait or construct and the numbers represent equal units from absolute zero. Observations can be compared as ratios or percentages. The ratio scale can, for example, state if a person has two or three times as much of the trait being measured as another person. Examples are: height; weight; age; time; Kelvin (absolute temperature).

B. **Frequency Distributions** arrange and describe observations so that the pattern of their distribution is easily seen.

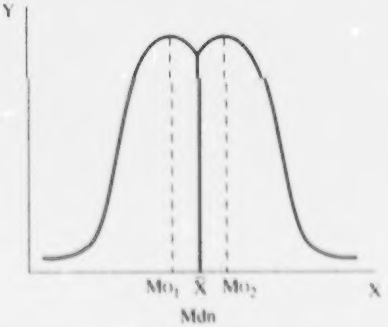
1. **In Tables,** the frequency of the distribution is constructed by summarizing data in terms of the number or frequency of observations in each category, score or score interval.

2. **In Graphs,** the data can be concisely summarized into bar graphs or histograms or into frequency polygons. Frequency polygons are constructed by joining the midpoints of the histogram bars.

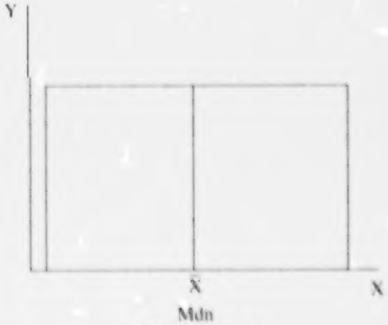
3. **The Normal Curve.** When a sufficiently large number of observations are made, the data takes on the shape of a bell-shaped or normal curve (the data is "normally distributed"). The right half of the curve is the mirror image of the left half; the observations are approximately symmetrical (see A below). Distributions that have two distinctly different points around which scores cluster are called "bimodal" curves (see B below). In a rectangular distribution, the frequency of scores is constant across all values of X (see C below). Skewed or asymmetrical distributions are seen in D and E below. In D (positively skewed), there are a greater number of scores at the low end and "tail off" at the high or positive end. If a test is very difficult, the number of scores might be greater at the low end (students didn't do very well) and tail off toward the high end. E shows negative skewness where the high scores are clustered together on the high end and "tail off" toward the left, the low or negative end. If a test is very easy, many students may do well and scores would "bunch up" at the high end, tailing off toward the low end, indicating a negatively skewed distribution of scores.



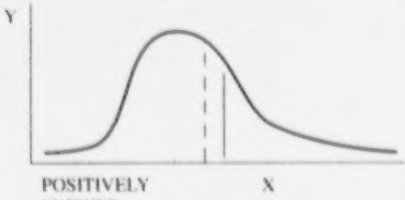
NORMAL
A



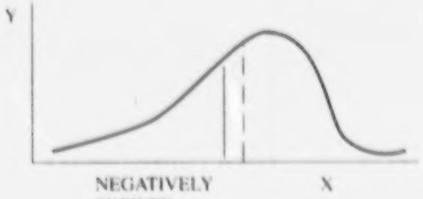
BIMODAL
B



RECTANGULAR
C



D



E

Key: X̄ = ________ Mo = ... Mdn = — — — —
Mean Mode Median

C. Measures of Central Tendency

1. **The Mode** (Mo) is the score (or category) that occurs most often in a set of data. The data can have more than one mode. (Ex: 2, 3, 4, 4, 4, 6, 8, 9, 10, 11, 11 - the mode is 4)

2. **The Median** (Mdn) is the score that divides a set of data in half when the data has been ordered from lowest to highest. It is the middle score in a set of odd number of observations, or the value that lies midway between the two middle values in an even number of observations. The median is the 50th percentile of a distribution - the point below which half the observations fall. There will always be an equal number of cases above and below the median. In the example above, the median is 6 since an equal number of observations (5) fall above and below 6. If one score in a distribution of scores is extremely high or low, the value of the median will not be affected. The median is the second most used measure of central tendency.

3. **The Mean** (Arithmetic Mean) is the "balance point" of a set of scores. It is obtained by finding the sum of all the scores and dividing by the N (number of scores in the set of scores). Ex 1: In the above example, the X̄ = 6.5; = 72 / 11 (N) = 6.5 (M or X̄). Ex 2: If 3 workers are 40, 45, and 65 years old, the Mean age is 50 yrs; 40 + 45 + 65 = 150 / 3 = 50. The Mean is preferred whenever possible and is the only measure of central tendency that is used in advanced statistical calculations because:

   a. It is generally the most reliable or accurate of the three measures of central tendency. The Mean generally fluctuates less widely than either the Mode or the Median.

b. The Mean is better suited to further arithmetical computations, thus is the most used measure of central tendency.

M or $\bar{X}$ = arithmetic mean
Σ = "the sum of"
X = each of the measurements or scores in turn
N = total number of measurements or scores

c. The Mean is sensitive to extreme scores and so is often not the appropriate measure to use when a distribution is skewed.

In a normal distribution, the mode, median and mean are the same, but in skewed distributions, they are not the same. In positively skewed distributions, the mean is greater than the median, and the median is greater than the mode (see D above). In a negatively skewed distribution, it is reversed. The mode is greater than the median, and the median is greater than the mean (see E above). In skewed distributions the mean is "pulled" further toward the tail of the distribution than either the median or the mode and the median is "pulled" further than the mode. The mode is the greater number of scores in skewed or normal distributions.

D. Measures of Variability (Dispersion)

Measures of variability or dispersion indicate how the distribution of scores spreads out from the center. The two most important statistical characteristics of any distribution of observations are its central tendency and its variability. Examples of measures of variability (dispersion) are:

1. **Range:** the simplest measure of variability, calculated by subtracting the lowest score from the highest score. Used only for ordinal, interval or ratio scales since the data must be ordered.

2. **Variance:** indicates the extent to which individual scores in a distribution of scores differ from one another.

3. **Standard Deviation:** is the square root of the variance. The standard deviation is the most widely used measure to describe the dispersion among a set of observations in a distribution. It is often used in computing other statistics.

E. Characteristics of the Normal Curve

The normal curve is symmetric about its mean. The half of the distribution to the right of the mean is the mirror image of the left half; the skewness of the distribution is zero. In a normal distribution, approximately 68% of all scores fall between one standard deviation above and one standard deviation below the mean, approximately 95% of all scores fall between two standard deviations above and below the mean, and approximately 99% of all scores fall between three standard deviations above and below the mean.

F. Standard Scores

Raw scores are frequently transformed to standard scores to help in interpretation. With standard scores, the mean and standard deviation are constant and known to the user. Any observation expressed in standard deviation units from the mean is a standard score. If the mean and standard deviation are known, the relationship of one score to that of others in the distribution is easily seen.

1. Z-Scores

The z-score is the most widely used standard score in statistics. A z-score of 1.5 means that the score is 1.5 standard deviations above the mean, or a z-score of -1.5 means that the score is 1.5 standard deviations below the mean. Z-scores have the same meaning in all distributions. The mean is always 0 and the standard deviation is always 1. However, because other standard score scales do not involve negative numbers or decimals they are easier to use and interpret. Z-scores can be converted to any other standard score using particular formulas.

2. T-Scores

The T-score is the most commonly used standard-score for reporting performance. T-scores may be converted from z-scores and are always rounded to two figures, therefore eliminating decimals. They are reported in positive, not negative numbers (i.e., 79.8=80). T-scores allow comparison within and among distributions. The mean is always 50 and the standard deviation is always 10.

G. Percentile Ranks

Percentile Ranks compare an individual score to all other scores in the distribution. To find the percentile equivalent for any observation in a normal distribution, the observation is converted to a z-score; the percentile equivalent is then read from a normal-curve table.

H. Correlation or Covariation

A correlation coefficient is a statistical summary of the degree or magnitude and direction of the relationship or association between two variables. Two variables are correlated if they tend to "go together". It is possible to have a positive correlation or a negative correlation. A causal relationship cannot be assumed between two variables being correlated. There are several measures of association.

1. **The Pearson Product-Moment Correlation Coefficient** is widely used in virtually all empirical disciplines. It is also called the "Pearson r" or "r".

2. **The Spearman Rank Correlation** is the degree to which scores maintain the same relative positions or ranks on two measures. Also known as "r ranks".

3. **Scatterplots** are also used to study the relationship between two variables. Each "dot" or "tally" represents the intersection of two scores, or pair of observations, i.e. heights of fathers and sons.

I. Linear Regression

Not only does the correlation coefficient between X and Y on a scatterplot describe the degree of association between X and Y, but this correlation will allow predictions to be made. The purpose of a regression equation is to make predictions on a new sample of observations from the findings on a previous sample of observations, i.e. to predict the height of sons who were not in the original sample, given father's heights. On a scatterplot, when the line connecting the actual means of Y for points all along the X-axis does not differ significantly from a straight line, the regression is said to be linear.

2. Inferential statistics

Inferential Statistics allows the researcher to make an inference about the relationship between independent and dependent variables in a population based on data collected from a sample or samples drawn from the population. To understand inferential statistics, one must distinguish between sample values and population values. When an entire population is not available for study (i.e., all Democrats or all Republicans), the researcher uses a "statistic" (sample value) to estimate a "parameter" (population value). Inferential statistical methods are similar to inductive reasoning - reasoning that goes from the particular to the general, from the seen to the unseen.

Any large collection or aggregation of things that is studied or about which inferences are made is called a population or parent population. A sample is a part, or subset, of a population. The sample should be selected in a deliberate way from the parent population so that the characteristics of the population can be estimated. Most applied statistical techniques are based on the assumption that an infinite population is being sampled.

A. Types of Samples

1. Random Samples

Before a sample will adequately serve as a basis for making estimates of population parameters, it must be representative of the population. If a sample is randomly drawn, it is representative of the population in all respects. A Table of Random Numbers is used for random sampling. Random selection of the members of a sample prevents any selection biases and allows generalizability of the sample findings to the population with a known margin of error (sampling error). Random sampling and stratified random sampling are further explained in the chapter on Research and Evaluation.

2. Systematic Sampling

An example of systematic sampling would be to select every hundredth word in a dictionary which would yield a systematic sample of words, or to select every third student from an alphabetical list. Systematic samples are easier to obtain than random samples and they are also representative samples. However, there is no satisfactory way to determine precisely how accurate the estimates are in the long run.

B. Sampling Error is the extent to which statistics vary from the true population parameters and may be due to effects of systematic factors (extraneous variables) or random factors (random fluctuations in subjects or experimental conditions). Due to sampling error, sample statistics deviate from population parameters. The smaller the sample, the greater the sampling error.

C. An Interval Estimate is a range or band within which the parameter is thought to lie, instead of a single point or value as the estimate of a parameter. The interval estimate is an important inferential statistical method used in behavioral research.

D. Sampling Distributions

1. **The Sampling Distribution of the Mean** is a frequency distribution, not of observations, but of means of samples, each based on n observations. It is the frequency distribution that would result if random samples of a certain size (n) were drawn from the parent population, the mean was computed for these n observations, then the process was repeated hundreds of times. The frequency distributions of these numerous mean values is the sampling distribution of the mean.

2. **The Standard Error of the Mean** is used as an estimate of the magnitude of sampling error. It is the standard deviation of the sampling distribution of the sample means.

E. Confidence Intervals

As has been stated, 68% of the cases in a normal distribution lie within 1 standard deviation of the mean. The .68 confidence interval is referred to as the 'confidence coefficient' of the confidence interval. However, it is not known if the particular mean that is being studied is one of the 68% that falls within that 1 standard deviation. Thus, it is usually best to have more than ".68 confidence coefficient" so that a wider confidence interval, the .95 confidence interval, is more commonly used. The parameter will then be contained within 95% (19 out of 20) or .95 confidence intervals, in the long run. To be even more confident, the .99 confidence interval is often used (1 out of 100).

F. **Central Limit Theorem** states that the distribution of samples (means, medians, variances, and most other statistical measures) approaches a normal distribution as the sample size, n, increases.

G. **Hypothesis Testing** and interval estimation both look at how inferences regarding the population are made from a sample of observations. A statistical hypothesis is a numerical statement about an unknown parameter. It is either true or false. By using inferential statistical methods, the researcher makes a decision, within a certain margin of error, as to whether the statistical hypothesis is tenable (is accepted) or whether it must be rejected as false. Hypothesis testing is the most widely used technique of statistical inference in educational and behavioral research.

1. **The Null hypothesis** is a statistical hypothesis where the assumption is made that there is no significant difference between means of the variables or groups being measured - that the means of population 1 & 2 are equal. The "no difference" statistical hypothesis is known as the "null hypothesis". Any difference found between means is due solely to sampling error. The null hypothesis is indicated by "Ho".

2. **The T-Test** is widely used to test many hypothesis. It is frequently encountered in published research in many disciplines. The t-test for differences in means allows the researcher to determine whether the difference in two groups is statistically significant. The nondirectional or "two-tailed" t-test is used to evaluate the null hypothesis since it is a "no difference" hypothesis. If the hypothesis is that the two population means are not statistically equal, a directional alternative to the null hypothesis is used, the "one-tailed" t-test. It is more powerful than the "two-tailed" t-test.

Assumptions of the t-test

a. The distributions of observations, in both population 1 and in population 2 are normal.
b. The variance of observations in population 1 and the variance of observations in population 2 are equal.
c. The observations in population 1 are independent of the observations in population 2.

3. **Type-I and Type-II errors** are the two types of errors that can be made in hypothesis testing. Ho can be rejected when it is correct-a Type I error; or Ho can fail to be rejected when it is incorrect-a Type-II error. The prespecified risk of making a Type-I error is usually set at the .05 level of statistical significance, but may be set at the .01 level of significance. If the researcher fails to reject the Ho, a Type-I error cannot be made, but a Type-II error can be made.

H. Types of Statistical Analysis

1. **Descriptive measures** quantify the degree of relationship or correlation between variables. The Pearson Product-Moment Correlation Coefficient (Pearson r) summarizes the magnitude and direction of the relationship between two variables using interval or ratio data. The Spearman Rank Order test is used with rank ordered data. These multivariate correlational techniques include multiple regression, factor analysis and partial correlation.

   a. Parametric tests are used to test hypotheses with stringent assumptions about observations. Observations must be normally distributed in the population, variances of populations are homogeneous and observations in the sample must be randomly drawn. Parametric tests are used with interval or ratio scales. Examples of parametric tests are t-test, ANOVA.

   b. Nonparametric tests are used with data in a nominal or ordinal scale. One cannot assume that there is a normal distribution of data or that there is homogeneity of variances. Examples of nonparametric tests are the Chi-Square test, the Mann-Whitney U test, the Wilcoxon test.

2. **Inferential Statistical Tests.** The primary scientific purpose of statistical methods is to allow generalizations about populations using data from samples. Inferential statistics allows this to happen. Selection of which test to use depends on the nature of the data (nominal, ordinal, interval, ratio) and the design of the research study (one group, multiple groups, one independent variable, multiple independent variables).

   a. The test for nominal data is the Chi-Square test.

   b. Tests for ordinal data are the Kolmogorov test, Kolmogorov Smirnov test, the Mann-Whitney U test, and the Wilcoxon Matched-Pairs Signed-Ranks test.

   c. Tests for interval and ratio data include t-test, Analysis of Variance (ANOVA,) Analysis of Covariance (ANCOVA) and Post-Hoc Tests for the Analysis of Variance.

CHAPTER 13

Outcome Studies

Psychotherapy involves interchanges between one or more therapists and one or more clients. The interchanges, both verbal and nonverbal, focus on understanding what the client(s) is (are) presenting. This understanding, then, is used in an effort to change the clients' ways of thinking, responding to situations, relating to others, and with some therapies, the way the client(s) is (are) feeling.

The results of psychotherapy (outcomes) received little emphasis until the early 1950's when H. J. Eysenck (1952) published an article summarizing twenty-four studies published between 1920 and 1950. In his article, he concluded that there were almost no positive results of therapy. If there were any positive results, he said, they may have been the result of spontaneous recovery. His thesis was challenged by many authors. A number of investigators have since found that psychotherapy is an effective form of treatment (Seligman, 1995). Smith, Glass & Miller (1980) used meta-analysis statistical methods for combining results of several outcome studies published between 1941 and 1976. Their conclusions (and others) were that psychotherapy is an effective treatment, but that no one therapy is consistently superior to any other therapy (Bergin and Garfield, 1994, Altekruse & Sexton, 1995).

Researchers are increasingly studying the effectiveness of therapies that include both psychological and medical interventions. Multi-modal treatment, combining more than one approach, including parts of different psychological therapies is also being studied.

There are many important questions relating to outcome studies. What is the criteria for improvement? Should "improvement" be the therapist's opinion, the behavior or feelings of the client, the opinions of family or friends, or other criteria? How long should changes in behavior or feelings last to be identified as "improvement"? There may be disagreement about the outcome of the therapy between client and therapist and/or others (Dill-Standiford, et al, 1988). It is not unusual for clients to see themselves as "cured" while their therapist sees them as unimproved or even as worse and vice versa.

Other questions relate to how the research is done. What is the measure used to indicate improvement? No reliable criterion of outcome studies is presently available. There are no guidelines for interpreting and analyzing data which is obtained. No long-term studies have been done and would be very difficult given the considerable effort and resources that would be needed. Some mental health problems are both chronic and, in some cases, cyclic, further complicating long-term research.

M. Seligman (1995) suggests the basic methods of studying psychotherapy outcomes:

1. efficacy study - a controlled, "scientific" study, using:
    - treatment-no treatment-placebo groups
    - treatment uses a scripted "manual" for a set number of sessions
    - clients usually meet criteria for a single diagnosed disorder
    - clients are followed for fixed time subsequent to termination
    - treatments not included: family, long-term dynamic, eclectic
2. effectiveness study - studies "in the field"
    - treatment is not of fixed duration
    - treatment is "self-correcting" - if one technique does not work, another is tried
    - clients "shop" for the most compatible therapist
    - clients usually have multiple problems; psychotherapy tries to relieve parallel and interacting problems
    - treatment is usually concerned with "improvements in general functioning" as well as relief of specific symptoms

NOTE

Roth and Fonagy (1996), in their comprehensive review of the outcome literature recognize that there is a range of commonly practiced psychological therapies. "However, there is a marked variation in the extent to which these differing orientations have been subjected to systematic evaluation. The consequence of this fact is that, relative to the frequency with which they are imployed, certain orientations - most particularly psychodynamic therapy - are under represented in (outcome literature)" (p. 32). It is their contention that knowledge of therapy outcomes is mainly knowledge of outcomes from research on therapies other than psychodynamic therapy.

THERAPEUTIC ALLIANCE

The therapist-client relationship is recognized by many researchers as being one of the most important aspects in the outcome of therapy. It is thought that a strong alliance provides a positive aspect to all treatments (Horvarth & Symond, 1993). Roth & Fonagy (1996) conclude that "interpersonal and intrapersonal factors appear to play a part" (p. 352) in the therapeutic alliance. Moras & Strupp (1982) and Kokotovic & Tracey (1990) (as cited in Roth & Fonagy, 1996) have found that clients who have experienced a poor therapeutic alliance and poor therapeutic outcome also have problems maintaining relationships, in general, and have poor family relations. The therapist, of course, is also important in the therapeutic alliance. It may facilitate the therapeutic alliance when the therapist addresses the client's negative feelings toward her/him. The skill of a good therapist may be in their ability to see problems that might make therapy difficult - "the capacity to monitor and maintain the therapeutic alliance" (Roth & Fonagy, 1996, p. 42).

THERAPIST VARIABLES

Although therapist factors in the therapeutic process have been studied, few have been found to be significant in the outcome of therapy. Those therapist factors found to have little, if any, significant relationship include: gender, age, race, specific personality factors, expectations of the therapist.

The following factors, however, have been found to have a greater relationship to outcomes:

Therapist Skillfulness: Therapist skillfulness (not longevity) and the level of therapist mental health make a significant contribution to a successful outcome. When clients specify the cause of positive change, they cite "personal qualities" of the therapist more than specific therapeutic techniques (Altekruse & Sexton, 1995). The ability of the therapist to form a therapeutic alliance is probably the most important therapist attribute in determining outcome (Roth & Fonagy, 1996).

Therapist Experience: There has been found to be a relationship between the experience of the therapist and outcome of therapy. More experienced therapists have better outcomes with more severely disturbed clients than less experienced therapists. Training of the therapist and therapists with more experience may have fewer clients who terminate prematurely and they may retain clients longer in treatment. (Roth & Fonagy, 1996, Altekruse & Sexton, 1995). Experienced therapists may be more comfortable with their techniques, creating a more therapeutic atmosphere. Experience may be particularly important when the therapist varies from the recommendations of a particular technique as well as when working with negative and hostile clients (Roth & Fonagy, 1996).

Therapist Training: There is some relationship between therapist training and outcome. Roth and Fongay (1996) conclude that this may be more true for some therapy modalities than others. They suggest that training in the psychodynamic therapies may necessitate a "fuller" professional training.

CLIENT VARIABLES

Client variables are very important with regard to outcome of therapy. It is seen as "a truism" that "psychological therapy requires the active participation of the (client) . . . a coordination of effort between (client) and therapist" (Roth & Fonagy, 1996, p. 42). In the research, it seems that client characteristics are better indicators of therapy outcome than other components such as characteristics of therapists, client-therapist match, or treatment variables (Frank, 1974; Luborsky, et al., 1980 as cited in *Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991). As with therapist variables, no clear and consistent findings have been found with a number of client variables (although more is known of the impact of client variables on outcome than of therapist variables). Client variables without clear findings include: gender, age, marital status, race, social class.

Client Diagnosis: Some researchers have found that clients with severe diagnoses such as schizophrenia showed less improvement than those with more narrow diagnoses such as phobias or specific anxieties (Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum, 1984 as cited in L. Seligman, 1990). Other research has found that clients with depression or anxiety may, at least at the beginning of treatment, tend to improve the most, but those with somatic problems showed less improvement (Frank, 1974; Luborsky, et al., 1971 as cited in *Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991). Pilkonis, Imber, Lewis, and Rubinsky (1984) found that chronicity of the emotional disorder was predictive of a poorer outcome.

Client Perceptions: Client's perceptions of the therapist's abilities to be helpful and encouraging, to help them face and understand their problems and themselves were seen to be important in the outcome of therapy (L. Seligman, 1990). Strupp and Bergin, (1969) conclude that clients who see their problems as psychological (not medical), and who expect therapy to be an active process are more likely to have a positive outcome.

Client Attractiveness: Studies have found that clients that were thought of by therapists as attractive and likeable generally had the most success in therapy (Nash, et al., 1965 and Strupp and Williams, 1960 as cited in *Preparatory Course for the Psychology Licensing Examination*, Vol. IV, 1991)

Client Intelligence and Education: More positive outcomes have been found to be associated with higher levels of intelligence and higher educational levels (Luborsky, et al., 1985, Ware, 1978).

TREATMENT FACTORS

Treatment Factors in therapy have been investigated.

Type of treatment - Overall, no one type of treatment has been found to be the best. However, a substantial amount of evidence has been found for the use of specific treatments for particular disorders (Roth & Fonagy, 1996, Altekrase & Sexton, 1995). For example, clients with panic disorders, agorophobia, and depression respond best to cognitive or cognitive-behavioral therapies sometimes in conjunction with medication; social skills training is used with persons with avoidant personality disorder. It seems to be the case that it is not the general theoretical approach, but the clinical protocol used with certain client problems that is important for successful outcomes. Clinicians may need to be trained in several different therapies in order to best treat clients with differing problems. Although the evidence is not clear that cognitive-behavioral and behavioral treatment is best for all diagnoses, insurance companies and HMO's generally tend to favor these treatments.

Length of Treatment - Some studies have found that, generally, there is no substantial difference between long and short-term therapy. Other studies have shown improvement levels off at about twenty-six sessions. However, when present and former clients were asked about the effect of the length of therapy in the *Consumer Reports* study, long-term treatment was seen to produce more improvement than short-term treatment. The greater amount of time (from 1 month or less to more than 2 years), the greater the improvement score (M.E.P. Seligman, 1995). The relationship between long or short-term therapy and a particular problem has not been reported.

Preparing Clients for therapy - Some studies have found that preparing clients for therapy prior to starting results in more positive therapy outcomes. Role preparation of the client by the therapist has an impact on the counseling outcome.

In General: It has been suggested that clients who are appropriately prepared for their role, who are viewed as suitable for treatment, who become engaged in a process of talking to the counselor whom they view as skillful, benefit from counseling (Seligman, M.E.P., 1995; Whiston & Sexton, 1993).

OTHER CLIENT ISSUES

1. Client drop out

A significant proportion of clients drop out prematurely, particularly lower socioeconomic clients. ". . . factors associated with premature termination include conventional, uncompromising views (e.g.: conformance with gender-role stereotypes), lack of anxiety regarding their problems, low levels of psychological sophistication or insight and they may be authoritarian. Other factors may include a high need for approval, lower education level, minority group membership and the expectation that the therapist will provide specific advice. Factors contributing to a client staying in therapy include the client tending to have high levels of perseverance, social integration, suggestibility, and anxiety. They may also have a low impulsivity level and an absence of antisocial or authoritarian attitudes" (*Preparation Course for the Psychology Licensing Examination*, Vol. IV, 1991 p. 48).

Active "therapist-shoppers" and active clients did better in treatment than passive recipients in the Seligman study (1995).

Seligman found that people whose choice of therapist or duration of treatment was limited by their insurance coverage did worse in therapy than those for whom this was not the case (M.E.P. Seligman, 1995).

CHAPTER 14

Prevention

Factors in the development and prevention of the psychiatric disorders.

PRIMARY TYPES OF FACTORS

1. Risk factors

The greater the number of risk factors to which individuals are exposed, the higher their susceptibility is to mental illness. Risk factors create stress on the psychic systems. When too much stress is applied the mental systems break down. Some risk factors are:

- Chronic illness
- Substance abuse
- Marital discord
- Handicaps or disabilities
- Low self-esteem
- Lack of insight
- Occupational stress
- Economic distress
- Problems with children
- Undiagnosed learning disability
- Unemployment
- Lack of leisure time
- Frequent relocations
- Shyness
- Social isolation
- Serial losses
- Social skills deficits
- Communication impairment in childhood

2. Protective factors

Protective factors reduce the possibility of the development of mental illness. The protective factors provide a buffer to and a way to deal with risk factors.

- No family history of psychiatric disorder
- No family history of debilitating medical illnesses
- Good physical health
- Regular exercise
- Intelligence
- Secure attachments to others
- Ability to tolerate intimacy
- Flexibility
- Open communication system
- Personal autonomy
- Clear boundaries
- Job satisfaction
- Financial security
- Academic achievement
- Social support systems
- Social skills
- Parental warmth
- Appropriate discipline as a child
- Bonding to family or other social models
- Effective coping skills
  Activity oriented
  Introspection
- Uses social/family supports
- Thinks through problems
- Searches for a greater meaning

OTHER TYPES OF FACTOR SYSTEMS

1. Developmental factors

The role of developmental processes across the life span in influencing the impact of these risks and protective factors and in shaping the process by which individuals develop resilience in the face of severe environmental stressors are of importance:

- An awareness of lifespan development
- The emergence and course of psychopathology
- Stress on developmental processes rather than single, static variables
- Identify specific risks at various points along the life span
- Design prevention interventions to reduce risk factors before they become entrenched
- The adaptive fit between the person and their environment

2. Cultural factors

Cultures differ in the definition of adaptive behavior and life span development. What is appropriate in one culture may be aberrant in another. It is important for the counselor to be aware of the differences in their clients' cultural norms.

3. Community factors

Rural societies, synonymous with the village, clan or extended family, will have different risk and prevention factors than the urban community where neighborhoods are tied by social forces such as ethnic or economic factors. Community prevention programs need to be developed by the culture in the community. The counselor needs to be in touch with the stressors and protective forces in their community.

4. Institutional factors

Schools - A preventative factor in the school would be the reduction of psychological stress associated with transfer to another school or into a new high school by the family or school staff. One intervention of the school counselor might be the maintenance of stable and supportive peer relationships among incoming students.

5. Occupational settings

Vary in the degree in which they support or subvert mental health. There are many systems at play on the job such as the nature of the "corporate culture," the services offered via health insurance or employee assistance programs as well as the nature of the work itself.

6. Family factors

The passage from one family developmental stage to another, the relationships between the marital partners or family executive system, and the parenting styles are a few of the factors residing in a family. The counselor needs to assess the family of origin as well as the current "family" to understand all the family factors.

7. Peer factors

- Positive peer relationships support mental health.
- Lack of peer support subverts mental health.
- Identification with delinquent youth groups promotes the development of psychopathology.

8. Biological factors

- Single and multiple gene risk and protective factors.

- Early menarche predisposes teen pregnancy. Some data suggests that family conflict, severe psychological trauma and father absence may precede, and possibly induce early menarche and its attendant hormonal increases.

OBJECTIVES OF PREVENTION

1. Prevention of mental health disorder

These objectives are measured by:
- The incidence of mental disorder.
- Reduction of the symptoms experienced among pre clinical cases.

Interventions can be enhanced by:
- Fitting intervention strategies to subsets of populations at risk.
- Increasing the acceptability of the interventions in order to minimize refusal rates.
- Increasing the cost effectiveness of interventions.

2. Reduction of risk and enhancement of protective factors

Protective factors can be enhanced by:
- Mental health promotion
- Clear definitions of mental health.

STRATEGIES OF INTERVENTION

1. Developmental timing

Finding "windows of opportunity" for appropriately timed interventions, making them more effective.

2. Focusing the intervention

Choosing the appropriate focus of an intervention, i.e., should an entire school be provided with a drug education program or should particular school populations be addressed in a planned series of interventions.

3. Precise identification of populations at risk

The more accurately a population at risk can be identified the more effective the prevention intervention will be. The population needs to be assessed for:
- The effectiveness and efficiency of the intervention.
- The readiness of relevant persons in the setting to continue to deliver a successful intervention after the trial is concluded.

CHAPTER 15

Career Development

◆ ◆ ◆ ◆ ◆ ◆ ◆

Career, in the United States, is "increasingly being defined as the combinations and sequences of life roles, the settings in which life roles unfold, and the planned and unplanned events that occur in people's lives." (McDaniels and Gysbers, 1992) As clients seek a context and meaning in their life, their vocation or career becomes evaluated for its appropriateness in meeting their life needs.

HISTORY

The evolution of career development can roughly be divided into four major periods:

1900-1950 - This period encompasses the industrial revolution and saw the development of "vocational guidance." This term was coined by Quincy Agassiz who established the Civic Service House in Boston in 1908. The focus was on how to choose work and "build a career."

1950-1980 - A broader, developmental view of work began during this period. The term "vocational development" was used frequently. More professionals began to enter the field and in 1966 the National Vocational Guidance Association was formed. Career development was defined as "the total constellation of psychological, sociological, educational, physical, economic, and chance factors that combine to shape the career of any individual." (McDaniels and Gysbers, 1992) The focus became more longitudinal rather than "what job will I choose next?"

1980-1990 - Up until this time the world of work or career was compartmentalized and considered to be separate from other life roles. During this period the work would began to be seen as an integral part of "life." Career consultation began to focus on "life-career" development.

1990 to present - The relationship between life and work continues to be redefined and clarified. Work is viewed over the life span.

BEST COPY AVAILABLE

HOW CAREER DEVELOPMENT IS INTEGRATED INTO THE COUNSELING PRACTICE

1. Career issues are often prominent in the counseling setting:

A. The company may be paying for mental health benefits.

B. The client may have been referred for evaluation by their manager.

C. They may have just lost a job.

D. They may be unhappy with their current job.

E. They may be addicted to their work and find it is impacting their health and other roles.

F. They may be seeking a higher quality of life which means a better, more fulfilling job.

2. The following framework for addressing career issues is structured after Gysbers and Moore (1987).

A. First

1. Identify the client goal or problem
2. Clarify the client-counselor relationship
3. Define the client-counselor responsibilities

B. Second - Gather information

1. How does the client view self, others and their world?
2. What themes does the client use to organize and direct their behavior?
3. What are the client's current status and environment like?
4. Do appropriate testing.

C. Third - Clarify client goals or problems.

D. Fourth - Develop individual career plans.

E. Fifth - Evaluate the results.

If the client has entered counseling to specifically address career issues this model can be followed. If career issues become a focus, related to other, more difficult issues, this model can be used as it is appropriate.

CAREER THEORIES

1. Decision models

Focus on how decisions are made and the criteria that are used. The factors that might affect decision making are:

A. The belief of self efficacy and self-esteem.

B. Risk taking style and comfort zone.

C. Values.

D. Investment of time, money or other resources.

2. Developmental models

Show process of change over time and influences that change lifestyle and career.

3. Sociological or situational models

Sociologists advocate that career development and career choices are influenced by the environment. The individual's choices are also influenced by their family, community, culture and social class as well as the geographical setting. These factors determine what a person is aware of, determines their risk taking behavior, and provides work identity and career mobility.

4. Structural models

Structural models measure and define individual differences in career in developmental terms. This information is then used to predict success in educational or vocational arenas. An example of a structural theory is trait-factoring. Developed by Frank Parsons (father of guidance) and author of "Choosing A Vocation" (1909), often called an actuarial or matching approach. This approach stimulated the development of assessment techniques and occupational information gathering. The trait-factor means you:

A. Study the individual.

B. Survey occupations.

C. Match the person with an occupation.

5. Needs based

Career is matched to individual needs.

6. Personality based

The best work situation is identified through the personality factors of an individual.

7. Cognitive theory

Comes out of the work in cognitive psychology. This approach looks at the biophysiological, linguistic, and psychological processes that form the cognitive functioning.

8. Comprehensive model

Encompasses all of the above.

LEADERS IN THE FIELD

1. Decision making models

H. B. Gelatt believed that the decision making process went on continuously and was constantly revisited. The process he outlined follows.

A. Recognizing the need for a decision.

B. Gathering data.

- Identifying possible courses of action.
- Considering the outcomes of each action.
- Reviewing values and if they are being supported in the possible outcomes.

C. Making a decision that may be a final decision or a decision in a series of decisions.

2. Developmentalists

A. There are four major developmentalists

1. Axelrad
2. Ginzberg
3. Ginsburg
4. Herma

B. These developmentalists share the belief that occupational choice progresses through three periods:

1. Fantasy - birth to 11 in which play becomes work oriented.
2. Tentative 11 - 17 which is made up of four stages:

   Interest
   Capacity
   Value
   Transition

3. Realistic 17+ with three stages

   Exploration
   Crystallization
   Specification

C. Linda Gottfredson

1. Gottfredson's theory is called "circumscription and compromise." She believes:
   - a. Self-concept is an important factor in all career choices.
   - b. We develop a range of acceptable work alternatives.
   - c. We select occupations within those alternatives that are compatible with our self-concept.
   - d. We rule out occupations through:
     - ◆ Sex typing
     - ◆ Staying within our social class
     - ◆ Inappropriate intelligence level, not able to succeed
     - ◆ Inappropriate interests based on an arbitrary value system
2. Her developmental stages are:
   - a. Orientation to size and power ages 3-5
   - b. Orientation to sex roles ages 6-8
   - c. Orientation to social valuation ages 9-13
   - d. Orientation to internal unique self ages 14+

D. Donald Super

Super was one of the early founders in the field of career consultation. He is very well known for his extensive involvement in the field. He has done longitudinal studies of students starting in the 9th grade and following them well into their 30's.

1. Super's general development process includes:
   - a. Growth - birth to 15 years
   - b. Exploration - 15-24 years
   - c. Establishment - 25-44 years
   - d. Maintenance - 45-64 years
   - e. Decline - 65+ years

2. Super delineated five vocational tasks:

   a. Crystallization - 14 - 18 years
   Formulating a general vocational goal.

   b. Specification - 18 - 21 years
   Moving from a tentative to a specific vocational choice.

   c. Implementation - 21 - 24 years
   Completing training and entering employment.

   d. Stabilization - 24 - 35 years
   Confirming a preferred choice by performing the job.

   e. Consolidation - 35+ years
   Becoming established in your career, advancing and achieving status.

3. **Super created the concept of life-career rainbow.** The rainbow includes the life span with its major stages and life space, made up of the roles we play. He identifies these roles as:

   a. Child
   b. Student
   c. Citizen
   d. Spouse
   e. Homemaker
   f. Parent
   g. Worker
   h. Leisurite
   i. Pensioner

3. Personality based

John Holland was a major proponent of personality based ideas. He believed a career choice was an expression of the individual's personality. He believed we choose a career based on the stereotypes we hold about different jobs or careers. Holland's typology includes six styles or types which are seen in the Strong Campbell assessment instrument.

A. Artistic

Creative and imaginative. Prefers self-expression through the physical, verbal or other media. Dislikes systematic and ordered activities.

B. Conventional

Practical and prefers ordered structured activities. Dislikes ambiguous and unsystematized tasks.

C. Enterprising

An extrovert that prefers leadership and persuasive roles. Dislikes abstract or cautious activities.

D. Investigative

Intellectual and prefers systematic creative investigation. Has poor persuasive and social skills.

E. Realistic

Aggressive and prefers explicit tasks requiring physical manipulation; has poor interpersonal skills.

F. Social

Prefers activities that inform, develop or enlighten others. Dislikes activities involving tools or machines.

4. Needs approach

A. Robert Hoppock

Hoppock placed high value on the identification of individual needs. He believed that if the person was clear about their needs, researched and became familiar with the occupations that were available to them, they could then make a good match and choose the right work. He believed that a person's needs changed over time so no single work event would last throughout a lifetime. As the needs changed, the work needed to change to meet those needs.

B. Ann Roe

Roe focused on the early childhood experiences that affected our adult needs. She also believed that careers were chosen to satisfy our needs. Roe developed a six "field-by-level" classification system:

1. Occupations:

- Professional and managerial - highest level
- Professional and managerial - regular
- Semi-professional and managerial
- Skilled
- Semi-skilled
- Unskilled

2. Fields:

- Service
- Business
- Managerial
- General cultural
- Arts and entertainment
- Technology
- Outdoor
- Science

5. Cognitive model

This model uses three basic organizers:

A. Structural Organization

How information is processed by the individual. This processing defines how they perceive themselves and their world.

B. Developmental Sequence

Differences in ways of thinking
Dualism - simplistic black and white thinking
Multiplicity - outer locus of control but includes multiple factors
Relativism - internal locus of control able to consider various options
Commitment within relativism - career identity and self become integrated.

C. Interactionism

The interaction between self and the environment (McDaniel and Gysbers 1992)

6. Comprehensive model

John Crites developed the *Career Maturity Inventory* and a comprehensive model of career counseling that includes three diagnoses of the career problem. After the diagnosis he suggests beginning with client-centered and developmental counseling, followed by psychodynamic techniques such as interpretation, followed by trait-factor and behavioral approaches. The three diagnoses to be made are:

Differential - what are the problems?
Dynamic - why have the problems occurred?
Decisional - how are the problems being dealt with?

CAREER COUNSELING COMPETENCIES

Consultation
General counseling
Implementation
Individual/group assessment
Information on education, training, employment, labor market and career resources
Management/administration

COMPUTER ASSISTED CAREER GUIDANCE SYSTEMS

C-LECT -	Computer-Linked Exploration of Careers and Training
COIN -	Coordinated Occupational Information Network
GIS -	Guidance Information System
SIGI PLUS DISCOVER -	System of Interactive Guidance and Information files

KEY TERMS

1. **Career -** a series of jobs and occupations one does.
2. **Career adaptability -** originally identified by D. Super as career maturity.
3. **Career counseling -** emphasizes career development paying attention to personal values and attitudes at work in a dynamic environment with a focus on self understanding, career information, planning and decision making.
4. **Career development -** a lifelong process in which we develop values, skills, interests and knowledge of the world of work.
5. **Career guidance -** a service that assists individuals in understanding and acting on their knowledge of self and of opportunities in work, education, and leisure.
6. **Career pattern study -** Super examined the vocational behavior of 9th graders all the way into their 30's.
7. **Differentiation -** becoming unique or different based on one's biology and the environment.
8. **I-power -** potential for self-improvement.
9. **Expressed interests -** those spoken or reported.
10. **Integration -** striving to become accepted or integrated in one's career.
11. **Job -** one person in one position doing a set of tasks.
12. **Lifestyle -** the person's orientation and preference in regard to career, family, leisure, place of residence, work climate, and overall style of life.
13. **Manifested interests -** determined by examination of what one is studying, previous jobs held and activities enjoyed.
14. **Occupation -** a definable work activity found in many locations.
15. **Outpatient counseling -** counseling provided to workers who are to be terminated.
16. **Retirement counseling -** counseling to assist people examine their options following employment.
17. **Vocational maturity -** J. Crites - a continuous developmental process moving through a series of stages and tasks. Tested interests - measured via inventories.

CHAPTER 16

Organizational Consulting

Consulting with an organization is a natural application of the counselors skills. When entering into a consultative role, either in your office or on-site at a business you still must maintain the highest ethical standards possible.

ETHICS OF CONSULTATION

Consultation by a practicing clinician holds the potential two major ethical issues:

- The site where you are consulting has current or former clients.
- The ethics of the consulting role which holds an identification of power.

The following are guidelines to follow when in the role of "consultant" (Corey, Corey, Callanan, 1991).

- First the consultant needs to be clear about who the "client" is. This is the person to whom the consultant owes primary allegiance. When working in an organization department managers may have different needs than the identified "client."
- As in the counseling relationship, the consultant must be alert to creating a dependent relationship. The job is to assist and provide expertise, not create a dependency.
- Cultural issues may be obvious in a company that is predominately ethnic or not so obvious as in a "corporate culture." The consultant must be informed of the cultural norms when the culture can be clearly identified, and seek out the cultural norms when they are not clearly seen.
- If a consulting client asks to become a clinical client, the situation must be clearly explored and a solution be found that meets the client's needs and remains an ethical solution. The consultant must maintain well-defined limits, and if the individual is in need of clinical help refer them to outside resources.
- If unbeknownst to the consultant, a previous client is at the worksite, information about the interactions must be entered into the closed client files. The highest integrity must be maintained at all times by the clinician/consultant.

BEST COPY AVAILABLE

THE RIGHTS OF CONSULTEES

1. Confidentiality

Before gathering any data the consultant needs to clarify and come to an agreement about who has a right to know the information gathered. These agreements are best made in writing between all parties involved. As in any situation when there is a danger to self or others, it is the consultant's responsibility to report the risk.

2. Informed consent

The following information needs to be included in the consultant's informed consent:

- Goals and process of consultation.
- Limits to confidentiality, such as above.
- The voluntary nature of consultation.
- Potential benefits.
- Potential risks.

The best way to approach informed consent is for consultants to ask themselves what they would want to know if they were in the clients' position. (Corey, Corey and Callanan, 1991)

ORGANIZATIONAL DEVELOPMENT CONSULTATION COMPETENCIES

1. Conceptual knowledge and theory

Organizational consultation is an alternative arena for the applied behavioral sciences. Organizations are systems so the system theorist is also at home here. In addition to the behavioral sciences the competent consultant also needs knowledge in management science, research methods and organizational change.

2. Self awareness

Like the counselor, the consultant uses the "self as instrument." He/she must be committed to the use of his/her skills and expertise while simultaneously being disengaged from the process. Self-knowledge about his/her own history, biases and world view as well as how they impact these consultative process are vital.

3. Consulting skills

Consultation includes, and is more than, listening well, observing what is not spoken, responding and putting agreements and thoughts into a written form. The consultant is also often asked to manage conflict, mediate and facilitate a group process. The successful consultant must also be able to market, contract and manage money and information.

4. Business and industry knowledge

The effective consultant must understand business language, principles and general practices. Many of the consultant skills are general to the consultative process and knowing something about the industry is also vital. Some consultants specialize in working with clearly identified industries such as health care, banking or hi-tech industries. (Winge, 1986)

THE CONSULTIVE PROCESS

An organization is much like a family. Organizational consultants deal with the needs of the organization much as they would deal with any system of people. The following general model can be used when working with an organization. After each stage the kinds of questions ethical consultants must ask themselves are posed. Following the general model is a list of specific approaches developed for the consultative process.

1. General stages of consultation

- Assess the needs of the organization. Do you have the skills to meet these needs?
- Create goals for the consultation. Are the companies goals ones you can ethically pursue?
- Plan how the goals are to be implemented. Do you have the expertise to implement or will you need outside help?
- Identify the management structure and how it will be impacted by the goals. Is the system strong enough to withstand a change in management structure? Is pre-change work required to safely create the management change necessary to implement the goals?
- Plan for the change process. Is the organization ready to create the changes needed?
- Identify areas of expected resistance. Do you have the skills to deal with the resistance and/or mediate problems?
- Pre-test. Are you qualified to administer the tests?
- Train. Can you provide the training needed or will you need outside help?
- Maintenance. How is change to be maintained? Do you need another contract for this process? Are you creating a dependent relationship?
- Analyze consultation and change process. What are the outcomes? Are they consistent with what was targeted initially?
- Post-test. Is the post-test testing correctly or is it designed to provide the answers you want?
- Reengineer activities based on outcomes. Now is the time for a reassessment of your skills and how well they have served the client.

2. Consultive models

A. Doctor-Patient Model

The consultant advises the customer about what is wrong and what should be done about the situation. This model is called the Doctor-Patient model because it is a parallel to a doctor diagnosing the patient's problem and providing a prescription to cure the problem. This model does not require a change or "cure" in the group.

B. Expert or Provisional Model

With this model the consultant acts as the "expert" and provides direct service to consultee who has hired them because they do not have the skills to deal with the problem at hand. The advantage of this approach is that it allows the consultee to step away from the problem while the "expert" solves it. The disadvantage of this model if the solution is successful, the consultee who hired them will get the credit for hiring the consultant and solving the problem. If the solution fails, the blame goes to the consultant.

C. Mediation Model/Systems Approach

Using the mediation process the consultant acts as a coordinator. The goal is to identify the services available from the variety of people who are there to solve the problem. The consultant may offer alternative plans that represent a mutually acceptable combination of several solutions. Mediation is a systematic method of problem resolution using resources that are already available within the system. This approach is thought to minimally disrupt the current system.

D. Collaborative Model or Process Consultation

This consultant is a facilitator for the problem solving process. The consultant gets the client to actively discover solution alternatives to their situation. In order to do this the client must define their problem clearly, analyze it thoroughly, identify workable solutions, choose and implement the solution of choice. The secondary goal of this method is to train the client to become more aware of their choices and increase their awareness of their own problem solving and decision making styles.

E. Group Consultation

Groups who have common tasks or problems often get stuck and need a consultant to help them get moving again. The primary purpose of this model is to provide new knowledge about human behavior to the group, and encourage them to work together. Caplan's C-Group model which follows, is an effective tool for this environment. (Caplan, 1994)

Caplan's Stages of Consultation - C group

- **Collaboration** - encourages members to work together as equals.
- **Consultation** - members must actively give and receive input from one another.
- **Clarification** - members must understand the relationship that exists between beliefs, feelings, and actions.
- **Confrontation** - members openly share constructive feedback.
- **Concern** - empathy for other members, their perspectives and situations is required.
- **Confidentiality** - keeping information within the boundaries of appropriateness is key.
- **Committment** - planning and implementing specific actions are necessary for completion of this model.

F. Agency Consultation From A Prevention Model

Agency consultation began in 1963 formally as a result of the passage of the Community Mental Health Centers Act. Included in the act is the philosophy that mental health is viewed from a local community perspective with an emphasis on prevention. The following is a prevention model as outlined by Caplan (Caplan, 1944).

Level 1 - First Level Goal - reduction in the number of mental disorders. This goal is reached by teaching life coping skills in the community. Consultation is a primary activity at this level.

Level 2 - Secondary Prevention Goal - reduction in the duration of mental disorders. This goal is reached by working with individuals to deal with their problems and increase support systems. This involves the treatment process.

Level 3 - Tertiary Prevention Goal - a reduction in the impairment that may have resulted from psychological disorders. The more success achieved at levels 1 and 2, the less need there is for level 3.

CHAPTER 17

Professional Practice

This chapter includes generally accepted guidelines for Professional Practice. In order to practice, you need to know the specific regulations that apply to your State or Regulatory agencies.

QUALITY OF CARE

As a professional it is your responsibility to provide the highest quality of services possible. If you do not you are vulnerable to a claim of substandard or negligent treatment. The malpractice insurance you carry protects you from liability lawsuits that are based on "negligence theory." You can be found guilty of negligence through commission or omission of treatment. It is your responsibility to constantly scrutinize your professional services. If you are offering, or failing to offer services as they are recommended by your professional association, but are not in the best interest of your client, you bear the consequences. The definition of "quality care" is a combination of "beliefs, attitudes, mores, values, ethics and laws. . ." (Woody, 1997) If you decide a particular kind of treatment is helpful to your clients, it is not entirely your decision to make. That type of treatment must be judged to be useful, and tested to be useful, through some form of scholarly peer review.

1. Scope of practice

The scope of your professional practice is defined by the Professional Associations you belong to, your Certifying Board, and the Regulatory Board in your state that provides you with a license. States have differing situations with certifications, practice laws and title laws. This means that your scope of practice may only include the use of a professional identification, or it may cover what you can and cannot do while providing services. It is your responsibility to know and understand how your work is defined by all the above.

You are legally bound to operate within your "scope of practice." As stated above, "scope of practice," may be defined for you by others. More specifically that means you may only provide services for identified areas in which you have adequate training, experience and competence.

EST COPY AVAILABLE

Insurance

When you are working with clients who are using their mental health insurance you must also abide by the regulations included in the contracts under which you agree to be reimbursed for services.

UNPROFESSIONAL CONDUCT

A counselor must abide by their "scope of practice" and any other regulations affecting how they practice their profession. What follows are general guidelines for behaviors to not engage in, and some suggestions how to make certain others know that you are practicing in a professional manner.

1. Credentials and qualifications

A. Misrepresenting the type or status of license or registration held by the licensee or registrant.

Have your license, certification or registration and any other business practice certificates displayed on the wall in your office.

B. Impersonating a licensee or allowing another person to use your credentials.

Make certain when you sign all contracts and insurance forms, you indicate how you are practicing. If you are billing under a supervisor's name, make certain that is clear.

C. Aiding and abetting an unlicensed person to engage in conduct requiring a license.

If you are supervising interns, make certain they do not misrepresent their status.

D. Misrepresenting or permitting the misrepresentation of your professional qualifications, affiliations, or purposes.

If somebody verbally or in writing misrepresents you, clarify the issue in writing.

Claiming an area of "specialty" without formal training or having skills that are greater than the average clinicians.

E. Performing or presenting yourself as able to perform professional services beyond your field of competence as established by your education, training or experience.

Maintain good records of all continuing education that enhances your services.

F. Advertise in a manner that is false or misleading.

Make certain all advertisement copy is proofed before it is printed and distributed.

2. Practice standards

A. Not following the ethical standards of your profession.

You are bound to the ethical standards of your profession even if you are not a member of the association.

B. **Intentionally or recklessly causing physical or emotional harm to a client.**

It is recommended that you always work with a supervisor or consultant with whom you can discuss questions and concerns that arise during the course of your work.

C. **Not making a diagnosis and treatment plan for a client.**

Therapy must be "academically and scientifically based." Every one of your clients should have an "individualized" diagnosis and treatment plan. If you choose not to do this you must have an academic and/or scientific construct to support your approach.

D. **Committing any dishonest, corrupt, or fraudulent act that is substantially related to the qualifications, functions or duties of your license.**

Always act honestly in any clinical or business interaction.

E. **Encouraging a client to use your counseling services rather than anothers, or encouraging them to leave therapy with another therapist for your services.**

If you believe there is unprofessional behavior occurring, and a client is at risk, you are required to report that professional to their licensing board and their professional organization. If you believe a client is not receiving the treatment they need that is not grounds for reporting in most states. In any case, do not involve the client.

F. **Having sexual relations with a client.**

NO NO NO NO - and if you know of anybody who is, report them as above.

G. **Failing to maintain confidentiality, except as otherwise required by law.**

Make certain your clients know during the first interview their rights and your requirements regarding reporting laws and when you are required to break confidentiality.

H. **Prior to the commencement of treatment, failing to disclose to the counselee, or prospective counselee, the fee to be charged for your professional services, or the criteria upon which such fees will be computed.**

Include this information in your initial Statement of Professional Services and ideally have all client's sign it.

I. **Accepting additional fees from your client for services performed at a location that is reimbursing you for your professional services.**

Do not seek additional reimbursement from a client beyond your wages.

J. **Sexual harassment.**

No no no no

K. **Taking care of your personal needs at the expense of the client.**

It is highly recommended that you partake of supervision of some kind, peer, group or individual, while practicing to ensure you are always seeking to provide the highest standard of quality possible. The more expert the supervisor the better.

L. **Allowing your personal life to become part of the therapeutic relationship.**

Having an office in your home is often a problem if the office in any way interfaces with your living quarters. The safest situation is an external office.

It is recommended that you do not give your home number to clients. Maintain a separate business telephone number.

M. Continuing to care for a client who is not making progress.

If a client is not making progress, completing prescribed homework assignments, or participating in the treatment contract it is the responsibility of the clinician to advise them if they do not follow the prescribed treatment plan they may need to terminate treatment or make an appropriate referral.

MALPRACTICE

The following have been considered grounds for the filing of a malpractice claim. The actions you might take to make certain this does not apply to you are included:

1. Negligent evaluation

An evaluation must be made within the first three visits, unless the first contact is a crisis. There should be a clinical evaluation and working treatment plan in place by this time.

2. Abandonment

Let your clients know what you will do in your "informed consent" information when their insurance runs out or they find they can no longer pay for your services. Ultimately, you are responsible for their care until you can find them alternatives. If you have provided them with at least three alternatives, and they have chosen not to follow up on them you have fulfilled your obligation as a provider. Make certain you document all your attempts to help them obtain alternate services before terminating your services.

3. Inadequate care or treatment

It is highly recommended that you engage in personal supervision or consultation while you are providing professional services to ensure all treatment options have been explored.

4. Failure to obtain informed consent

Create a document that describes all the information under client's rights and have your client read and ideally sign a copy.

5. Breach of confidentiality

When in doubt, do not discuss clients and make certain your records are properly protected at all times.

6. Breach of contract

If any changes in your initial agreements happen, make a written record and have your client sign a copy for your records.

7. Useless treatment

If your client is not making any progress you might consider:

- Discussing it with your supervisor or consultant
- Making a referral to another professional
- Terminating treatment

8. Dual relationship

A. **Do not enter into any other relationship with a client who is engaged in counseling with you.** Any other relationship you have with a counseling client in any other arena is considered a Dual Relationship. There have been some time frames identified pertaining to when you can develop a different relationship, such as a friendship (2 years) by state law and professional group. In general, it is a good idea to just say no. Some examples of dual relationship are:

1. **Business relationships**

   If you are already involved with someone in a business arena and they ask you to do therapy for them, or a member of their family, you may act in an information and referral capacity only. The business relationship precludes a therapeutic relationship. A therapeutic relationship precludes a business relationship.

2. **Sexual relationships**

   Includes former clients. The length of time after therapy has not been made clear. The best time frame is never.

3. **Personal relationships i.e., friendships**

   Some states provide legal guidelines about how long a clinician must wait before entering into another role with the client. The safest decision is to never enter into a relationship of any kind with a former client.

4. **Tradeout or bartering**

   The only form of "currency" that cannot be misjudged in its value is money. No other form of payment should be received for services rendered.

5. **Accepting gifts**

   The wisest decision is to decline any gift offered and view the offering of a gift within the clinical framework.

B. If a dual relationship is unavoidable, the following has been offered as a way of handling the situation:

- Secure informed consent.
- Seek consultation.
- Document and self-monitor.
- Obtain supervision.

LEGAL ETHICAL

The individual counselor carries the responsibility of reporting laws that have been created by national and local, regulating agencies, professional laws, business codes, and pertinent legislation. It is your responsibility to be familiar with all of these regulations. It is also the individual's responsibility to honor his/her own conscience and to always keep the best interests of clients, colleagues and society in mind. In most current cases, if you are told to break or breach a law or code by your employer, supervisor or any person in authority in the arena in which you are acting, and the case is brought to court, you will be held personally responsible for your actions. Also, if you are working in a location, or are a member of a group counseling practice and have knowledge of abuse that is going unreported, you may be held liable if you fail to report.

1. Vicarious liability

If a clinician is in any kind of business relationship with another mental health professional he/she are subject to vicarious liability of the other clinician's practices. If the practice appears to be combined, the liability increases. When in relationship with another professional it is recommended there be full disclosure regarding:

- Substance abuse
- Management of personal finances
- Sexual relations.

2. Client's rights

Informed Consent

When you consider working with new clients there is some information they should be provided with in order for them to make an informed decision about whether or not they want to enter into a professional relationship with you. Some of the information it is recommended you should provide in writing is:

A. The cost of treatment.

If you use a sliding fee schedule they need to know the criteria you use to determine their fee. Other billing information you should provide them with is:

1. Your method of billing.

2. How you would like to be paid (per visit, monthly, through insurance).

B. **How many visits you believe this particular phase of treatment will include.**

C. **How many visits are covered by their insurance carrier,** what their co-payment, deductible or other prior payment requirements may be and what you will do if they wish to continue in treatment and no longer have insurance coverage. These policies must be congruent with any contract you may have with their insurance carrier.

D. **What type of counseling services you provide.** Help them to understand the type of interventions or lack of them they are to expect. How much of the work is their responsibility, i.e., keeping a journal, bibliotherapy.

E. **The advantages and disadvantages of counseling.**

F. **The potential risks of counseling.**

G. **The potential effect it may have on their immediate or extended family, job, social activities, or other aspect/s of their life.**

H. **Alternatives to counseling.** This might include community services that are available.

I. **When you break confidentiality, i.e., danger to self or others.**

J. **How and when you may be contacted (i.e, emergencies, vacations).**

3. Duty to warn (general)

When a client is a danger to themselves or others, there is an exception to the privilege and the therapist is permitted, and sometimes mandated by the state, to confide in someone else to protect the client and the public. Make certain that you know the reporting laws in your state.

A. Risk of Suicide

You may not detain a client, but if you feel that the client is in physical danger when they return to their particular situation, you may report this information to the local police and the people whose names you obtained in your intake interview who are to be contacted in case of emergency. Of course, you have given ALL of your clients, ideally in writing, your procedures for dealing with situations where a person is a danger to themselves or others. See Chapter on Crisis and dealing with Suicide.

B. Danger to Others

If you believe a client is going to hurt someone when he/she leaves your office you need to call that person or the police to attempt to warn them of the danger. If they are HIV positive and actively engaging in unprotected sex and not revealing their medical status to their partner/s, there is general agreement that you may notify an identified partner, or the health department only if you have written medical confirmation of their medical status.

4. Confidentiality

The therapist's ethical standards require him/her to treat ALL communications, in any medium, as confidential. Even the fact that someone is a client is a private matter. When you meet the client on the street he/she must be the one to initiate acknowledgment that you know one another.

The client may permit the therapist to communicate with another, by signing a release form. A release is needed to communicate to other professionals, provide information to health insurance companies or any other outside party. If a client is using a Third Party Payer, and the company has told you they already have signed a release, it is good business practice to get one for yourself to keep in your file before releasing records. When you get the release signed, it is a good time to advise the client of your standards on confidentiality and that when the records leave your office (approved by them) you have no control over how they are used by their insurance carrier.

You need to plan what you will do in the case you go on vacation you need to provide for their needs and inform them about what they should do if you are unexpectedly not available.

Who has access to your records is also an issue. If you hire temporary office staff you must plan how clinical information will be safeguarded. Staff needs to be selected with care, trained regarding record handling and supervised regarding their performance.

When a client dies the responsibility for confidentiality does not expire. If parents ask for a copy of their dead adult child's clinical records you do not necessarily have to provide those records. It would be the determination of the court in your region as to whether they have a right to the records.

5. Privileged communications

Definition - an exchange of certain information between two persons in a relationship that requires trust and confidentiality.

Privileged communication is the legal affirmation of the ethical principle of confidentiality. It is the right of the client and means that he/she can invoke privilege to prohibit the testimony of the mental health professional if they are subpoenaed to testify in court. If invoked, the professional cannot be cited for contempt for refusing to testify about information obtained during treatment.

Communicating information about counseling interactions or materials can only occur upon the consent of the client, preferably in writing. Counselors may provide information to the public, subordinates, peers or supervisors if the content is general and in no way identifies the client. Information should be communicated in an unbiased, objective, factual manner.

Privilege is held by the patient, a guardian or conservator of the patient when they or the personal representative of the patient if the client is dead. Privilege can exist between psychological corporations, therapists, partnerships or other groups and their clients.

Guidelines for exceptions to privileged communication include the following:

A. The services of the therapist were sought to enable or aid anyone in committing or planning to commit a crime or to escape detention or apprehension after commission of a crime.

B. The therapist has reasonable cause to believe that the patient is a danger to self or others and disclosure of the communication is necessary to prevent the threatened danger.

C. The therapist was appointed by the Court to examine the client.

D. The proceeding was brought by or on behalf of the client to determine competency.

E. The patient is under age (refer to State definitions) and the therapist has reasonable cause to believe the patient has been the victim of a crime and that disclosure of the communication is in the best interests of the child.

F. The client waives the privilege.

G. The mental or emotional condition of the client is submitted into evidence as an issue in litigation.

Check with your individual State to determine what regulations apply to your professional practice. In some states you are required to testify in criminal actions, in others you are not. It is important that you know where you stand legally where you are practicing.

6. Laws relating to minors

It is your professional responsibility to know the definition of a minor in your state and the regulations that cover your professional relationship with them. A minor is a person who has not become emancipated by age, marriage, membership in the armed services, or petition of the courts.

Mental health professionals are constrained from treating minors without parental knowledge and consent. Therapists who choose not to notify parents must document their reasons for doing so and the child must be old enough to make an informed decision. When the minor is being treated without parental knowledge, the therapist holds the privilege in a legal proceeding. Of course, the minor is entitled to a completely confidential relationship with the therapist. If the parents are sending the child in for treatment and paying the bill, they may be able to compel the therapist to reveal the content of sessions, except in a legal proceeding. The responsible clinician will discuss the guidelines regarding confidentiality with both the parents and the minor at the start of treatment. Clinicians may offer to give the parent general information in the form of a progress report, that has been reviewed with the minor.

7. Court appearances

When subpoenaed by an attorney to be in court for a trial you are required to be there as a "fact" witness, not an "expert" witness. The "fact" witness is only required to provide hard information such as dates of treatment, fees paid, and clinical notes if released by the client or "certified" by the judge. An "expert" witness provides opinions. If, while appearing as a fact witness, an attorney asks for an opinion, you are not required to respond unless the attorney agrees to change your status, and pay a fee for your services, when the judge determines that an expert witness is necessary for a trial.

REPORTING

Recommended reporting guidelines:

1. When

When you believe there is a "clear and eminent danger to the client or others" you must take reasonable action or inform the responsible authorities. It is recommended you consult with other professionals when possible. The responsibility for the client's situation must be taken only after very careful consideration. The client should be given personal responsibility for their actions as soon as possible.

2. What

If you are called into a court proceeding or administrative hearing as a result of your report it is recommended you only provide the name, address, of a child or elder, nature and extent of the person's condition, and any other information required by the protective agencies involved including the information that led you to suspected danger or abuse.

3. Who

If you are licensed or credentialed most states consider you a "mandated" reporter. This means you must report any knowledge or reasonable suspicion of danger to self or others. Usually laws protect the person making the report from criminal or civil suit as long as the report was not made falsely. In some states not reporting danger or abuse is a misdemeanor.

4. Abuse

A. Child Abuse

When any one or more of the following acts are inflicted by another (even if the child "deserved it," or appears to be a willing participant) other than by accidental means:

1. Physical Abuse

- Sexual assault
- Lewd and lascivious acts
- Rape
- Incest
- Sodomy
- Oral copulation
- Penetration of a genital or anal opening
- Corporal punishment resulting in injury
- Abuse in out-of-home care
- A child showing injury, bruises from spanking should be reported
- Neglect
- Abandonment
- Emotional and verbal abuses are difficult to prove, it is the counselor's judgment call on this one.

2. Who to report to

Child protection agencies in your area. These may be the police, department of social services or a child protective agency. Usually a report to one covers all but you should check to see if you need to report to more than one agency.

3. What to report:

   Name and current location of child, nature and extent of the injury and any other information requested by the child protective agency.

4. What to consider for consultation

   a. How to assess and investigate for child abuse when you are the therapist for the child.

   b. Should you inform the family before or after the report?

   c. NEVER follow someone else's opinion about whether to report. IT MUST BE YOUR DECISION!

B. Spousal abuse

When you believe your client or the partner of your client is at risk for physical abuse, it is your responsibility to protect her/him from further injury. Of course, you have disclosed to him/her that you will report "danger to self or others" in your initial contact with the client. If your client is the person at risk and does not have a safe place to go, provide information about safe houses and shelters in the area. Make a call to any referral you provide so that you know about availability and that the timing of the departure from the dangerous situation is in the best interest of the client. You may not detain a client, but if you feel that the client will be in physical danger on returning to a particular situation, you may report this information to the local police. Remember to give ALL of your clients, preferably in writing, your procedures for dealing with situations where a person is a danger to themselves or others.

C. Elder abuse

When any one or more of the following acts are inflicted by another, other than accidental means:

- Physical Abuse
- Fiduciary Abuse
- Neglect
- Abandonment

Who To Report To:

- Elder care custodians.
- Medical practitioners.
- Nonmedical practitioners and employees of an elder protection agency.

You may report suspected cases of infliction of mental suffering on elders. Reports of suspected physical abuse should be made as soon as possible by telephone to an elder protection agency and in writing soon after. Check your particular state's regulations for guidelines.

D. Acquired Immune Deficiency Syndrome (AIDS)

There is not yet a universally accepted standard on reporting to a spouse or committed partner about the infection of your client. There does seem to be a trend granting clinicians immunity from legal action for any breach of confidentiality in these situations (Woody, 1997).

REFERRAL & CONSULTATION

Whenever you counsel a client, and at any time you believe you identify an issue that is beyond your scope of effective practice, YOU MUST attempt to make some type of referral. If a referral is not possible consult with a professional who has expertise in that area.

In cases of emergency referral, the client should have been advised at the beginning of treatment of the therapists availability. The clinician does not need to be available 24 hours a day but should make arrangements for client care when they are not available. If the client is not able to make emergency arrangements themselves the information should be made available to their family or caretakers.

RECORD KEEPING

Written records must be kept for clients to support the level of quality of care. These records must be clear and accurate. They must be secure and confidential. Records that are made immediately after a session are considered to be more accurate than if they are made some time later. Records are the property of the clinician. The client has a right to a copy of their records (and must pay for the copies) unless the clinician believes it is not in the best interest of the client. Parents have the right to a copy of their children's records. If the clinician believes it is not in the best interest of the child to release their records it then becomes the decision of the attorneys or the court to make that judgment. If the parent has a legal determination made, the clinician must hand over the records or suffer the punishment of the court.

When a counselor moves or retires they should place an ad in the local newspaper advising former clients as to the availability of their records. A counselor should make plans in their will or estate documents as to the disbursement or storage of their client records. Records may be transferred to another mental health professional or family member who will maintain the integrity of the records.

Clinical records are best kept in a prescribed format. The following system is generally accepted in the mental health field:

1. Clinical notes

All your clinical notes need to be kept in an orderly manner. Your notes need to be written in an objective and non-biased manner. One model that is used in the medical area is the SOAP method.

Subjective experience
Objective observations
Assessment of this information
Prognosis or recommendations made to the client.

Another model is a Problem Oriented method. This means that every note taken is coded to a specific problem that has been identified for this client. Interventions are coded to the problem they are meant to address. Include all interactions that take place in the counseling session that have to do with changes in the original *Professional Services Agreement*. You need to record all other exchanges of information, such as telephone calls or contacts that occur outside the office. Clinical records are the property of the client and must be given to them upon request unless you determine that it would be detrimental to the client's well-being to read them.

Clinical notes can include:

A. Test information

B. Correspondence

C. Audio tapes

D. Video tapes

E. Electronic data and communication

F. Telephone messages

G. Any other documents

All of these are considered to be private professional information and should not be available to anyone other than the client unless specified by National or State regulations.

It is a good idea to keep all financial records separate from your clinical notes.

2. Record storage

Storage and disposal of information by electronic or other means must maintain the confidentiality and privacy of the client.

Records should be under two locks. A person should have to go through two locking devices to have access to the records.

3. Availability to other professionals when you are on vacation and they are covering your clients

When a colleague is covering your professional practice and you are out of town and potentially not available for consultation, the colleague needs to have access to the client records you have asked them to be responsible for. If this is electronic information it might be on a disc that is secured under double lock, one lock can be a security code to open the data bank.

4. Abbreviations, initials and symbols

When you are making your clinical notes, either in your own office or in a job situation, never make any mark that is not readily understandable by others within your profession. Unknown marks can be misconstrued, and if you are working in a facility that is audited by a Medical or Hospital Accreditation Board, these notes will be marked unsatisfactory and create a problem for accreditation of the facility. If your notes are demanded in a legal action, any marks that are not professionally identifiable can cause you to be cited for unprofessional record keeping and your validity can be challengedand the reason for the change.

When you make an error or wish to change an entry do not erase or use "whiteout." Rather, draw a line through the material to be changed or removed and place the date and your initials on that line. Indicate in your new entry the corrected information which was deleted or changed and the reason for the change.

These are some examples of the acceptable abbreviations that have evolved over time:

ac	Before Meals
ADA	American Diabetic Association
A.D.L.	Activities of Daily Living
adm.	Admitted (admission)
AM	Morning
AMA	Against Medical Advice
amt.	Amount
appt.	Appointment
A.S.A.P.	As Soon As Possible
A.T.	Activity Therapy
AWOL	Absent Without Official Leave
BA	Baker Act
BFB	BioFeedBack
b.i.d.	Twice a Day
B/P	Blood Pressure
Bx	Behavior
c̄	with
CAT Scan	Computerized Axial Tomography
CBC	Complete Blood Count
CNS	Central Nervous System
c/o	Complains Of
Con't	Continued
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular Accident
D/C	Discharge
D/c	Discontinued
DD	Date Dictated
Diff	Differential
DOB	Date Of Birth
Dr.	Doctor
DTs	Delirium Tremens
DS	Discharge Summary
Dx	Diagnosis

ECT	ElectroConvulsive Therapy
pt.	Patient
QA	Quality Assurance
q	Every
qd	Every Day
qh	Every Hour
qid	Four Times a Day
RN	Registered Nurse
R/O	Rule Out
R.O.	Reality Oriented
RT	Recreational Therapy
Rx	Take - Treatment - Prescription
s̄	Without
s	With
Soc.hx	Social History
Soc.Ser.	Social Service
stat	Immediately
TB	Tuberculosis
TTH	Twenty Three Hour
tid	Three Times a Day
TP	Treatment Plan
UR	Utilization Review
UKN	Unknown

BIBLIOGRAPHY

Adler, A. (1963). *The Practice and Theory of Individual Psychology.* Patterson NJ: Littlefield, Adams.

Aguilera, D. C. and Messick, J. M. (1978). *Crisis Intervention: Theory and Methodology.* St. Louis: The C. V. Mosby Co.

Allen, M., & Yen, W. (1979). *Introduction to Measurement Theory.* Pacific Grove CA: Brooks/Cole.

Altekruse, M. K., & Sexton, T. L. (1995). *Mental Health Counseling in the 90's: A Research Report for Training and Practice.* Tampa, FL: National Commission for Mental Health Counseling.

American Counseling Assoc. (1995) *Code of Ethics and Standards of Practice.* Alexandria, VA: ACA.

APA Diagnostic and Statistical Manual of Mental Disorders. (4th ed.) (1994). Washington, DC: American Psychiatric Association.

Anastasi, A. (1988). *Psychological Testing.* (6th ed.). NY: Macmillan.

Atwood, J. D., & C. R. (1987). *Treatment Techniques for Common Mental Disorders.* Northvale New Jersey: Jason Arranson.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review,* 84(2), 191-215.

Bandura, A. (1969). *Principles of Behavior Modification.* NY: Holt, Rinehart & Winston.

Bandura, A. (1974). Behavior therapy and models of man. *American Psychologist,* 29, 859-869.

Bandura, A. and Walters, R. H. (1963). *Social Learning and Personality Development.* NY: Holt, Rinehart, and Winston.

Bass, S. P. S. (1986,). *Child Abuse Seminar - Workbook.*

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs, 1.*

Beck, A. (1967). *Depression: Clinical, Experimental, and Theoretical Aspects.* NY: Harper & Row.

Beck, A. T. (1979). *Cognitive Therapy and the Emotional Disorders.* NY: New American Library.

Beck, A. T. and Rush, A. J., Shaw, B. F. and Emery, G. (1979). *Cognitive Therapy of Depression.* NY: Guilford Press.

Beck, A. T., Freeman, A and Associates. (1990) *Dependent Personality Disorder in Cognitive Therapy of Personality Disorders.* Guiford Press, NY, NY, 1990, pp 283-308.

Beck, A. T., Freeman, (1990) *A Cognitive Therapy of Personality Disorders.* Guilford, NY, NY, 1990.

Bee, H. (1994). *Lifespan Development.* Harper Collins College.

Bee, H. (1995). *The Journey of Adulthood.* Prentice Hall.

Behavior Today, Trans. (1991). A Legal primer for psychotherapists and counselors. NY: *Psychotherapy Today.*

Bell, J. (1960). *Public Health Monograph.*

Bellack, A. S., & Hersen, M. (Eds.). (1988). *Behavioral Assessment - A Practical Handbook.* New York: Pergamon Press.

Benjamin, A. (1969). *The Helping Interview.* (Second ed.). Boston: Houghton Mifflin.

Benson, H., M.D. (1975). *The Relaxation Response.* NY: William Morrow & Co.

Bergin, A. E., & Garfield, S. L. (1994). *Handbook of Psychotherapy and Behavior Change.* NY: Wiley.

Berne, E. (1961). *Transactional Analysis - in Psychotherapy.* NY: Ballantine.

Berne, E. (1963). *The Structure and Dynamics of Organizations and Groups.* NY: Ballentine Books.

Berne, E. (1977). *Intuition and Ego States.* San Francisco, CA: Transactional Publications 1772 Vallejo St.

Berne, E. (1964). *Games People Play.* NY: Grove Press.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.) *Handbook of Psychotherapy and Behavior Change* (pp. 257-310). NY: Wiley.

Bion, W. (1991). *Attention and Interpretation.* NY Basic Books.

Blanck, G. R. (1974). *Ego Psychology - Theory and Practice.* (First ed.). (Vol. 1). Columbia: Columbia University Press.

Blanck, G., & Rubin, B. (1979). *Ego Psychology II - Psychoanalytic Developmental Psychology.* New York: Columbia University Press.

Blinder, M. D., Martin G. (Ed.). (1972). Family therapy. *The Journal of the Family Therapy Institute of Marin.* (Vol. 1).

Bourne, E.J. (1995). *The Anxiety and Phobia Workbook.* Oakland, CA: New Harbinger.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis,* 39, 350-373.

Bowlby, J. (1958). Psychoanalysis and child care. In J. D. Sutherland (ed.), *Psychoanalysis and Contemporary Theory.* London: Hogarth.

Bowlby, J. (1973). *Attachment and Loss.* NY: Basic Books.

Bowman, P. (1982). Clinical bias against activity in women and implications for female self-concept. *International Journal for the Advancement of Counseling,* 5, pp. 63-71.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., Vogel, S. (1970). Sex role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology,* 34, 1-7.

Brown, D., & Brooks, L. (1984). *Career Choice and Development.* SF: Jossey Bass.

Brownstein, S., Weiner, M., & Green, S. (1987). *How to Prepare for the Scholastic Aptitude Test.* NY: Barrons.

Bugental, J. F. T. (1978). *Psychotherapy and Process - The Fundamentals of an Existential-Humanistic Approach.* Reading, MA: Addison-Wesley.

Butcher, H. (1989). *Manual for the Restandardized MMPI.* MN. University of Minnesota.

Buzan, T. (1983). *Use Both Sides of Your Brain.* NY: EP Dutton.

CAMFT. (1985,). *Malpractice - a Problem to be Avoided (Legal Issues).* Paper presented at the Annual Conference, Hyatt Burlingame CA.

CAMFT. (1988,). *Testifying and Expert Witness: Rules, Responsibilities and Rewards.* Paper presented at the Expert Witness Workshop, San Francisco.

Cameron, C. (1994). Women survivors confronting their abusers: issues, decisions, and outcomes. *Journal of Child Sexual Abuse,* Vol. 3(1), 7-35.

Campbell, J. (Ed.). (1971). *The Portable Jung.* NY: Penguin Books.

Campbell, R. (1996). *Psychiatric Dictionary.* (7th ed.). New York: Oxford University Press.

Carter, B., & McGoldrick (Eds.). (1989). *The Changing Family Life Cycle - a Framework for Family Therapy* (2nd ed.). (Vol. 1). Needham Heights, MA: Simon & Schuster.

Cashdan, S. (1988). *Object Relations Therapy - Using the Relationship.* NY: W.W. Norton.

Catalog. (1992). *American Psychiatric Press, Inc.:* APP 1400 K Street, N.W. Washington, DC 20005 800-368-5777.

Center, C. P. (1985). *Child Abuse Prevention Handbook.* Sacramento CA: Office of the Attorney General.

Charatan, F. (1985). Depression and the elderly: diagnosis and treatment. *Psychiatric Annals,* May, Vol. 15(5), 313-316.

Chessick, R. D. (1985). *Psychology of the Self and the Treatment of Narcissism.* Northvale, New Jersey: Jason Aronson.

Churchman, C. W. (1968). *The Systems Approach.* NY: Dell Publishing.

Cohen, R., Montague, P., Nathanson, L., & Swerdlick, M. (1988). *Psychological Testing: An Introduction to Tests and Measurement.* Mountain View CA: Mayfield.

Corey, G., Corey, M., & Callanan, P. (1988). *Issues and Ethics in the Helping Professions.* Pacific Grove CA: Brooks/Cole.

Corey, G. (1990). *Theory and Practice of Group Counseling.* Pacific Grove CA: Brooks/Cole.

Corey, G., & Corey, M. (1991). *Groups: Process and Practice.* (4th ed.). Pacific Grove CA.

Corey, G. (1996). *Theory and Practice of Counseling and Psychotherapy* (5th ed.). Pacific Grove, CA: Brooks/Cole Pub. Co.

Corsini, R. J. (1979). *Current Psychotherapies.* (2nd ed.). (Vol. 1). Itasca, Illinois: F.E. Peacock Publishers, Inc.

Crites, J. (1981). *Career Counseling: Models, Methods, and Materials.* NY: McGraw Hill.

Cronbach, L. (1990). *Essentials of Psychological Testing.* (5th ed.). NY: Harper & Row.

Davanloo, M. D., Habib (Ed.). (1980). *Short-Term - Dynamic Psychotherapy.* (Vol. 1). New York, NY: Jason Aronson.

Davison, G. & Neale, J. (1994). *Abnormal Psychology.* (6th ed.). New York: John Wiley & Sons.

DeFrancis, V. (1963). *Child Abuse: Preview of a Nationwide Survey.* Denver, CO: American Humane Association.

Dennis, W. (1966). Creative productivity between the ages of 20 and 80 years. *Journal of Gerontology,* 21, 1-8.

Dickson, D., Crystal, H., Mattiace, L & Masur, D. (1992). Identification of normal and pathological aging in prospectively studied nondemented elderly humans. *Neurobiology of Aging,* Jan.-Feb., Vol. 13(1).

Dill-Standiford, T. J., Stiles, W. B., & Rorer, L. G. (1988). Counselor-client agreement on session impact. *Journal of Counseling Psychology,* 35 (1), 47-55.

Draves, William A. (1984). *How to Teach Adults.* Manhattan Kansas:LERN Press

Drummond, R. (1988). *Appraisal Procedures for Counselors and Helping Professionals.* Columbus OH: Merrill.

Duckworth, J.C. (1995). *MMPI & MMPI-2: Interpretation Manual for Counselors and Clinicians* (4th ed.). Bristol, PA: Accelerated Development.

Edwards, B. (1979). *Drawing on the Right Side of the Brain.* New York: St. Martin's Press.

Egan, A. L. (1977). *Anxiety Free Statistics.* Dubuque, IA: Kendall/Hunt Publishing Co.

Egan, A. L. and DiBartolo, R. (1976). *Research: The Magical Mystery Trip.* Dubuque, IA: Kendall/Hunt Publishing Co.

Ellis, A. (1971). *Growth Through Reason.* Palo Alto CA: Institute for Rational Living.

Ellis, A., & Harper, R. A. (1975). *A New Guide to Rational Living.* Englewood Cliffs, NJ: Prentice-Hall.

Ellis, M. (Ed.). (1977). *Understanding Yourself.* NY: A&W Visual Library.

Ellis, A., & Grieger, R. (1977). *Handbook of Rational-Emotive Therapy* NY: Springer.

Ellis, A. (1962). *Reason and Emotion in Psychotherapy.* Native Therapy. Y: Lyle Stuart.

Elmer, E. and Gregg, G. S. (1967). Developmental characteristics of abused children. *Pediatrics,* Vol. 40, 596-602.

Erikson, E. H. (1959). Identity and the life cycle. *Psychological Issues,* Vol. 1.

Erikson, E. H. (1963). *Childhood and Society.* NY: Norton.

Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology,* Vol. 16, 319-324.

Eysinck, H. H. (1966). *The Effects of Psychotherapy.* NY: International Science Press.

Faiver, C., Eisengart, S., & Colonna, R. (1995). *The Counselor Intern's Handbook.* Pacific Grove, CA: Brooks/Cole Publishing Company.

Frankl, V. E. (1959). *Man's Search for Meaning.* (1st ed.). (Vol. 1). New York NY: Pocket Books.

Frank, J. D. (1974). Therapeutic components of psychotherapy: A 25 year progress report of research. *Journal of Nervous and Mental Disease,* 159, 325-342.

Freedman, A. M., Kaplan, H. I., & Sadock, B. J. (1976). *Modern Synopsis of Psychiatry/II - Comprehensive Textbook.* (Illustrated ed.). Baltimore MD.

Freud, S. (1924). *A General Introduction to Psychoanalysis.* (First ed.). (Vol. 1): Liveright Publishing Co.

Freud, S. (1933). *New Introductory Lectures on Psychoanalysis* (Strachey, James, Trans.). NY: W.W. Norton.

Freud, S. (1949). *An Outline of Psychoanalysis* (Strachey, James, Trans.). NY: W.W. Norton & Co.

Freud, S. (1961). *Civilization and Its Discontents* (James Strachey, Trans.). NY: W.W. Norton.

Freud, S. (1964). *The Future of an Illusion* (Robson-Scott, W.D., Trans.). (Revised ed.). NY: Anchor Books.

Gabbard, G. (1995). *Treatments of Psychiatric Disorders.* (2nd ed.). Washington DC: American Psychiatric Press.

Gabbard, G. O. *Treatment of Psychiatric Disorders* Vol. I & II. (1995) Wash. DC: American Psychiatric Press, 1995.

Galanter, M. (Editor), Kleber, H. (Editor) (1994). *The APA Press Textbook of Substance Abuse.* Washington DC: APA Press.

Gamwell, L. and Tomes N. (1995). *Madness in America.* Cornell University Press.

Gardner, H. (1978). *Developmental Psychology: An Introduction.* Boston, MA: Little, Brown and Co.

Gendlin, E. T. (1979). Experiential psychotherapy. In R. J. Corsini (Ed.), *Current Psychotherapies.* Itasca, ILL: F. E. Peacock Publishers, Inc.

Gazda, G. (1989). *Group Counseling: A Developmental Approach.* (4th ed.). Boston: Allyn & Bacon.

Gelso, C. J., & Carter, J. A., (1985). The relationship in counseling and psychotherapy: components, consequences, and theoretical antecedents. *Counseling Psychologist,* 13, 155-243.

George, R. (1988). *Group Counseling: Theory and Practice.* Englewood Cliffs: Prentice-Hall.

Gill, J. L. (1983). *Personalized Stress Management - A Manual for Everyday Life and Work.* (First ed.). (Vol. 1). San Jose, CA: Counseling & Consulting Services Publications.

Gilligan, C. (1982). *In a Different Voice - Psychological Theory & Women's Development.* Cambridge MA: Harvard University Press.

Gilliland, B. E. and James, R. K. (1993). *Crisis Intervention Strategies.* CA: Brooks/Cole.

Glasser, W. (1965). *Reality Therapy - a New Approach to Psychiatry.* NY: Harper & Row.

Glasser, W. (1970). *Mental Health or Mental Illness? Psychiatry for Practical Action.* New York: Harper & Row.

Glasser, W. (1984). *How to Take Effective Control of Your Life.* NY: Harper & Row.

Goldberg, A. (Ed.). (1985). *Progress in Self Psychology* Vol. 1. NY: Guilford Press.

Goldenberg, H. (1983). *Contemporary Clinical Psychology.* Monterey, CA: Brooks/Cole Publishing Co.

Gotlib, I. H., and Colby, C. A. (1987). *Treatment of Depression.* Elmsford, NY: Pergamon Press.

Gough, H. G. (1987). *CPI - California Psychological Inventory Administrator's Guide.* Palo Alto, CA: Consulting Psychologists Press.

Graham, K. R. (1977). *Psychological Research - Controlled Interpersonal Interaction.* (First ed.). (Vol. 1). Monterey CA: Brooks/Cole Publishing Co.

Green, A. H. (1976). A psychodynamic approach to the study and treatment of child-abusing parent. *American Journal of Orthopsychiatry,* Vol. 52(1), 73-81.

Green, V. (1995). Comparing child victims and adult survivors: clues to the pathogenesis of child sexual abuse. *Journal of the American Academy of Psychoanalysis*, Win. Vol 23(4), 655-670.

Greening, T. (Ed.). (1980). *Journal of Humanistic Psychology*. (Vol. 20 #1). San Francisco, CA: Journal of Humanistic Psychology 325 9th St.

Greenspan, S. I. (1981). *The Clinical Interview of the Child*. New York: McGraw Hill.

Guilford, J. P. (1978). *Fundamental Statistics in Psychology and Education*. NY: McGraw-Hill.

Gurman, A. S. (Ed.). (1981). *Handbook of Family Therapy*. NY: Brunner/Manzel.

Gutheil, T. *Malpractice Prevention for Clinicians* (1995). Washington, DC: APA Press.

Haley, J. (1963). *Strategies of Psychotherapy*. NY: Grune & Stratton.

Haley, J., & Hoffman, L. (1967). *Techniques of Family Therapy*. NY: Basic Books.

Haley, J. (1973). *Uncommon Therapy - The Psychiatric Techniques of Milton H. Erickson*. NY: W.W. Norton.

Haley, J. (1976). *Problem Solving Therapy*. NY: Harper & Row.

Hall, C. S. (1954). *A Primer of Freudian Psychology*. (1st ed.). (Vol. 1). New York: Mentor Books.

Hall, C. L., Gardner. (1957). *Theories of Personality*. NY: John Wiley & Sons.

Hall, C. S., & Nordby, V. J. (1973). *A Primer of Jungian Psychology*. (1 ed.). (Vol. 1). New York: Signet.

Harlow, H. (1958). The nature of love. *American Psychologist*, 13, 673-685.

Harper, R. A. (1959). *Psychoanalysis & Psychotherapy - 36 systems*. NY: Prentice Hall.

Hendricks, G. W., Barry. (1982). *Transpersonal Approaches to Counseling and Psychotherapy*. Denver Co: Love Pub.

Heppner, P. P., & Dixon, D. N., (1981). A Review of the interpersonal influence process in counseling. *Personnel & Guidance Journal*, 59, 542-550.

Heppner, P. P., & Heesacker, M. (1983). Perceived counselor characteristics, client expectations, and client satisfaction with counseling. *Journal of Counseling Psychology*, 30, 31-39.

Herlihy, B., & Golden, L. (1990). *Ethical Standards Casebook*. (4th ed.). Alexandria VA: ACA.

Herr, E., & Cramer, S. (1988). *Career Guidance and Counseling Through The Lifespan: Systematic Approaches*. (3rd ed.). Genview IL: Scott, Foresman/Little, Brown.

Hersen, M., Kazdin, A. E., & Bellack, A. S. (Eds.). (1983). *The Clinical Psychology Handbook* (1st ed.). (Vol. 1)., NY: Pergamon Press.

Hershenson, D., & Power, P. (1985). *Mental Health Counseling: Theory and Practice*. NY: Pergamon Press.

Hood, A. B., and Johnson, R. W. (1991) *Assessment in Counseling*. Alexandria, VA: ACA.

Hopkins, B., & Anderson, B. (1985). *The Counselor and the Law*., VA: ACA.

Hopkins, K., & Stanley, J. (1990). *Educational and Psychological Measurement and Evaluation*. NJ: Prentice-Hall.

Hopkins, K. D. and Glass, G. V. (1978). *Basic Statistics for the Behavioral Sciences*. NJ: Prentice-Hall.

Horn, J. and Donaldson, G. (1980). Cognitive development in adulthood. In O. G. Brim Jr. and J. Kagen (eds). *Constancy and Change in Human Development*. Cambridge, MA: Harvard University Press.

Horne, A. & Passmore, J. (1991). *Family Counseling and Therapy* (2nd ed.). Itasca, IL: F.E. Peacock Publishers.

Horner, A. (1975b). Stages and processes in the development of early object relations and their associated pathologies. *International Review of Psycho-Analysis*, 2, 95-105.

Horner, A. (1979). *Object Relations and the Developing Ego in Therapy*. NY: Jason Aronson.

Horney, K. (1940). *New Ways in Psychoanalysis.* NY: Norton.

Horney, K. (1951). *Neurosis and Human Growth.* London: Routledge and Kegan.

Horney, K. (1967). *Feminine Psychology.* New York: Norton & Norton.

Howard, K., Orlinsky, D., & Lueger, R. (1994). Clinically relevant outcome research in individual psychotherapy. *British Journal of Psychiatry,* 165, 4-8.

Hummel, D., Talbutt, L., & Alexander, M. (1985). *Law and Ethics in Counseling* (Trans.). NY: Van Nostrand.

Hunter, R. S., Kilstrom, N., Krabill, E. N., and Loda, F. (1978). Antecedents of child abuse and neglect in premature infants: A perspective in a newborn intensive care unit. *Pediatrics,* Vol. 61, 629-635.

Ingram, D. H. (1987). *Final Lectures - Karen Horney - The Lectures on Psychoanalytic Technique Given in the Last Months of Her Life.* NY: WW Norton & Co.

Isaacson, L. (1985). *The Basics of Career Counseling.* Boston: Allyn & Bacon.

Ivey, A. E., & Simek-Downing, L. (1980). *Counseling and Psychotherapy - Skills, Theories, and Practice.* (1st ed.). (Vol. 1). NJ: Prentice Hall.

Ivey, A. E. (1986). *Developmental Therapy.* CA: Jossey Bass.

Jaffe, D. T. (Ed.). (1975). In search of a therapy - personal accounts of the training, change, and growth of nonconventional therapists (*Psychotherapy Theory Treatment* ed.). NY: Harper Colophon.

James, W. (1963). *Psychology.* Greenwich, CT: Fawcett.

Jongsma, A. E., Jr. & Peterson, M. (1995). *The Complete Psychotherapy Treatment Planner.* New York: Wiley.

Jourard, S. M. (1974). *Healthy Personality - An Approach From the Viewpoint of Humanistic Psychology.* (3rd ed.). (Vol. 1). NY: MacMillan.

Jung, C. (1954). *The Development of Personality.* Collected works. (Vol. 17). NJ: Princeton University Press.

Kangas, J. and Bradway, D. (1971). Intelligence at middle age: a thirty-eight year follow-up. *Developmental Psychology,* 5(2), 333-337.

Kaplan, H. I. and Sadock, B. (1991). *Synopsis of Psychiatry* (6th Ed.). Baltimore: Williams & Watkins.

Kaplan, H. I. and Sadock, B. J. (1981). *Modern Synopsis of Psychiatry III.* MD: Williams and Wilkins.

Kazdin, A. E. (1994) Methodology, design and evaluation in psychotherapy research. In Bergin, A. E., & Garfield, S. L. *Handbook of Psychotherapy and Behavior Change.* pp. 19-71.

Keirsey, D., & Bates, M. (1978). *Please Understand Me - Character & Temperament Types.* CA: Prometheus Nemesis Books.

Kessler, J. W. (1966). *Psychopathology of Children.* NJ: Prentice-Hall.

Khan, H. I. (1982). *Personality - The Art of Being and Becoming.* Oregon: Omega Press - Sufi Order.

Knobloch, H. and Pasamanic, B. (eds.). (1974). *Developmental Diagnosis.* MD: Harper and Row.

Kohut, H. (1977). *The Restoration of the Self.* NY: International Universities Press, Inc.

Kroeger, O., & Thuesen, J. M. (1988). *Type Talk - The 16 Personality Types That Determine How We Live, Love and Work.* (1st ed.). (Vol. 1). NY: Dell.

Kubler-Ross, E. (1969). *On Death and Dying.* NY: Macmillan.

Laing, R. D. (1967). *The Politics of Experience.* NY: Ballentine Books.

Lambert, M. J., Shapiro, D. A., & Bergin, A. E. (1986). The effectiveness of psychotherapy.: In S. L. Garfield & A. E. Bergin (Ed.). *Handbook of Psychotherapy and Behavior Change.* NY: Wiley, pp. 157-211.

Lazarus, R., & Monat, A. (Eds.). (1979). *Personality* (3rd ed.). NJ: Prentice-Hall, Inc.

Lederer, W. J., & Jackson, D. D. (1968). *The Mirages of Marriage.* NY: WW Norton & Co., Inc.

Levinson, D. (1978). *The Seasons of a Mans Life.* NY: Knopf.

Lieberman, M., Yalom, I. D., & Miles, M. B. (1973). *Encounter Groups: First Facts.* NY: Basic Books.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* NY: Guilford Press.

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational and behavioral treatment: confirmation from meta-analysis. *American Psychologist*, 48, 1181-1209.

Livneh, H. and Sherwood, A. (1991). Application of personality theories and counseling strategies to clients with physical disabilities. *Journal of Counseling and Development*, July/August, 69 (6), 525-538.

Lorenz, K. (1937). Companionship in bird life. In C. Schiller (ed.), *Instinctive Behavior.* NY: International Universities Press.

Luborsky, L. et. al. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, 42, 602-611.

Lynch, M. (1975). Ill health and child abuse. *Lancet*, Vol. 2, 317-319.

Maccoby, E. E. and Jacklin, C. N. (1974). *The Psychology of Sex Differences.* CA: Stanford: Stanford University Press.

Maccoby, E. E. and Jacklin, C. N. (1974). What we know and what we don't know about sex differences. *Psychology Today* 109-112.

MacKinnon, R. A. and Michels, R. (1971). *The Psychiatric Interview in Clinical Practice.* PA: W. B. Saunders Co.

Mahler, M. S., Bergman, A., & Pine, F. (1975). *The Psychological Birth of the Human Infant - Symbiosis and Individuation.* NY: Basic Books.

Maloney, M. P., & Ward, M. P. (1982). *Psychological Assessment - a Conceptual Approach.* NY: Oxford University Press.

Mann, A., Stanley. (1987). *Triggers - A New Approach to Self-Motivation.* NJ: Prentice Hall.

Marlin, E. (1989). *Genograms.* New York, NY: Contemporary Books.

Maslow, A. H. (1962). *Toward a Psychology of Being.* (Rev. ed.) NY: D. Van Nostrand Co.

Maslow, A. H. (1972). *The Farther Reaches of Human Nature.* NY: Penguin Books.

Masterson, J. (1988). *The Search for the Real Self - Unmasking the Personality Disorders of Our Age.* NY: The Free Press.

Maxmen, J. (1991). *Psychotropic Drugs Fast Facts.* NY: WW Norton.

McDaniels, C., & Gysbers, N. (1992). *Counseling for Career Development.* CA: Jossey Bass.

McKay, M., David, M. & Fanning, P. (1981). *Thoughts and Feelings: The Art of Cognitive Stress Intervention.* CA: New Harbinger Publications

McKowen, C. (1986). *Thinking about Thinking, a Fifth-Generation Approach to Deliberate Thought.* CA: William Kaufmann Inc.

McNeill, B. W., May, R. J., & Lee, V. E. (1987). Perceptions of counselor source characteristics by premature and successful terminators. *Journal of Counseling Psychology*, 34, 86-89.

Mehrens, W., & Lehmann, I. (1984). *Measurement and Evaluation in Education and Psychology.* (3rd ed.). NY: Holt, Rinehart & Winston.

Mehrens, W., & Lehmann, I. (1987). *Using Standardized Tests in Education.* (4th ed.). NY: Longman.

Meltzoff, J and Kornreich, M. (1970). *Research in Psychotherapy.* NY: Atherton Press.

Messing, J. (1993). Mediation: an intervention strategy for counselors. *Journal of Counseling and Development*, Sept.-Oct., Vol. 72(1), 67-72.

Meyer, R. G. (1983). *The Clinician's Handbook - the Psychopathology of Adulthood and Late Adolescence.* (Fourth ed.). MA: Allyn and Bacon, Inc.

Miller, J. B. (1986). *Toward a New Psychology of Women.* (2nd ed.). MA: Beacon Press.

Minuchin, S. (1974). *Families & Family Therapy.* MA: Harvard University Press.

BEST COPY AVAILABLE

Mullan, H., & Rosenbaum, M. (1962). *Group Psychotherapy - Theory and Proctice.* NY: Collier-Macmillan Limited/The Free Press.

Mumford, E., Schlesinger, H. J., and Glass, G. V. (1979). Problems in analyzing the cost offset of including a mental health component in primary care. *In Institute of Medicine: Mental Health Services in General Health Care.* Washington, DC: National Academy of Sciences.

Myers, I. B., & Myers, P. B. (1980). *Gifts Differing.* CA: Consulting Psychologists Press.

Myers, I. B., & McCaulley, M. H. (1985). *Manual: A Guide to the Development Use of the Myers-Briggs Type Indicator.* CA: Consulting Psychologists Press.

National Coalition Against Domestic Violence (1996). Unpublished Communication. Denver, CO.

Nevill, D. D. (1981). *The Values Scale.* Palo Alto CA: Consulting Psychologists Press.

Nicholi, A. M., Jr. (ed.). (1988). *The New Harvard Guide to Psychiatry.* MA: Harvard University Press.

Ohlsen, M., Horne, A., & Lawe, C. (1988). *Group Counseling.* NY: Holt Rinehart and Winston.

Okun, B. (1996). *Effective Helping, Interviewing and Counseling Techniques* (5th ed.). Monterey, CA: Brooks/Cole Publishing Company.

Osipow, S. (1983). *Theories of Career Development.* (3rd ed.). Englewood Cliffs NJ: Prentice Hall.

Othmer, E and Othmer, S. C. (1994). *The Clinical Interview Using DSM-IV.* Vol. 1. Washington, DC: American Psychiatric Press.

Perls, F., Hefferline, R. F., & Goodman, P. (1951). *Gestalt Therapy - Excitement and Growth in the Human Personality.* NY: Delta Book.

Perls, F. S. (1969). *Gestalt Therapy Verbatim.* Utah: Real People Press.

Phares, E. J. (1988). *Clinical Psychology: Concepts, Methods, and Profession.* IL: The Dorsey Press.

Piaget, J. (1963). *The Origins of Intelligence in Children.* NY: Norton.

Piaget, J. (1955). *The Language and Thought of the Child.* NY: Meridian Books.

Piaget, J. (1947). *The Psychology of Intelligence* (Malcom Piercy, D.E. Berlyn from French, Trans.). Totowa, New Jersey: Littlefield, Adams & Co.

Pomeroy, W. B. (1975) The diagnosis and treatment of transvestites and transsexuals. *Journal of Sexual & Marital Therapy,* 1:215-224.

Preparatory Course for the Psychology Examination (1991). Association for Advanced Training in the Behavioral Sciences: Westlake Village, CA.

Preston, J., and Johnson, J. (1992). *Clinical Psychopharmacology Made Ridiculously Simple.* NY: Medmaster.

Rapoport, J. L. (1989). *The Boy Who Couldn't Stop Washing.* NY: Dutton.

Rapoport, L. (1970). Crisis intervention as a mode of brief treatment. In R. W. Roberts and R. H. Nee (eds.). *Theories of Social Casework.* IL: University of Chicago Press.

Reid, W. H. (1989). *The Treatment of Psychiatric Disorders.* Revised for the DSM III-R. NY: Brunner/Mazel.

Restak, R. (1984). *The Brain.* NY: Bantam Books.

Riegal, K. F. and Riegal, R. M. (1972). Development, drop and death. *Developmental Psychology,* 6, 306-319.

Riker, H., & Myers, J. *Older Persons in Experiencing and Counseling Multicultural and Diverse Populations,* (3rd ed.). Nicholas A. Vace, S., DeVaney, J. (Eds.), 91-117. Accelerated Development, Inc: Muncie, IN.

Ricco, G. L. (1983). *Writing the Natural Way - Using Right-Brain Techniques to Release Your Expressive Power.* LA: JP Tarcher Inc.

Robyn, S., Fremouw, W. (1996). Cognitive and affective styles of parents who abuse their children. *American Journal of Forensic Psychology,* Vol. 14(4), 63-79.

Rogers, C. (1951). *Client-Centered Therapy.* MA: Houghton Mifflin.

Rogers, C. R. (1961). *On Becoming a Person.* MA: Houghton Mifflin Co.

Rogers, C. R., & Stevens, B. (1967). *Person to Person - the Problem of Being Human.* NY: Pocket Books.

Rogers, C. R. (1942). *Counseling and Psychotherapy.* MA: Houghton Mifflin.

Rossi, E. L., & Ryan, M. O. (Eds.). (1985). *Life Reframing in Hypnosis by Milton H. Erickson.* NY: Irvington Publishers.

Roth, A. & Fonagy, P. (Eds). (1996) *What Works for Whom?* The Guilford Press, NY.

Russell, P. (1979). *The Brain Book.* NY: EP Dutton.

Sarason, I. G., & Sarason, B. R. (1996). *Abnormal Psychology: The Problem of Maladaptive Behavior.* NJ: Prentice Hall.

Sager, C. J., & Kaplan, H. S. (Eds.). (1972). *Progress in Group and Family Therapy.* NY: Brunner/Mazel, Inc.

Satir, V. (1972). *Peoplemaking.* (1st ed.). (Vol. 1). Palo Alto, CA: Science & Behavior Books.

Satir, V. (1983). *Conjoint Family Therapy.* (3rd ed.). Palo Alto, California: Science & Behavior Books, Inc.

Schaefer, E. S. (1959). A circumflex model for maternal behavior. *Journal of Abnormal and Social Psychology,* 59, 226-35.

Schaie, K. & LaVouvie, V. (1974). Generational versus ontogenetic components of change in adult cognitive behavior: a fourteen year cross-sequential study. *Developmental Psychology,* Vol. 10, 305-320.

Schaie, K. W. (1985). *Adult Mental Abilities Test.* Palo Alto, CA: Consulting Psychologists Press.

Schneidman, E. (1985). *Definition of Suicide.* NY: Wiley.

Seligman, L. (1986). *Diagnosis and Treatment Planning in Counseling.* NY: Human Sciences Press.

Seligman, L. (1990). *Selecting Effective Treatments.* San Francisco: Jossey-Bass.

Seligman, L. (1994). *Introduction to DSM-IV Workshop.* Boston: MA.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist,* 50 (12), 965-974.

Semans, J. H. (1956). Premature ejaculation: A new approach. *Southern Medicine Journal,* 49:353-357.

Sexton, T. L., & Whiston, S. C. (1991). A review of the empirical basis for counseling: implications for practice and training. *Counselor Education & Supervision,* 30, 330-354.

Sharf, R. (1992). *Applying Career Development Theory to Counseling.* Pacific Grove CA: Brooks/Cole.

Shelton, J. L., & Levy, R. L. (1981). *Behavioral Assignments and Treatment Compliance - a Handbook of Clinical Strategies.* IL: Research Press.

Shertzer, B., & Linden, J. (1979). *Fundamentals of Individual Appraisal: Assessment Techniques for Counselors.* Boston MA: Houghton Mifflin.

Shneidman, E. D. (1985). *Definition of Suicide.* NY: John Wiley and Sons.

Skinner, A. E. and Castle, R. L. (1969). *Battered Children: A Retrospective Study.* United Kingdom: National Society for the Prevention of Cruelty to Children.

Skinner, B. F. (1938). *The Behavior of Organisms: An Experimental Analysis.* NY: Appleton-Century-Crofts.

Skinner, B. F. (1948). *Walden 2.* (1st ed.). (Vol. 1). Toronto, Ontario: Macmillan Co.

Skinner, B. F. (1953). *Science and Human Behavior.* NY : Free Press.

Skinner, B. F. (1971). *Beyond Freedom & Dignity.* New York: Bantam.

Smith, M. L., Glass, G. V., and Miller, T. I. (1980). *The Benefits of Psychotherapy.* Baltimore: Johns Hopkins University Press.

Spitz, R. A. and Wolf, K. M. (1946). Anaclitic depression. *Psychoanalytic Study of the Child,* 2, 313-42.

Spitzer, R. I. (Ed.). (1994). *DSM-IV Casebook: A Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, D. C.: American Psychiatric Association.

Steele, B. (1994). Psychoanalysis and the maltreatment of children. *Journal of the American Psychoanalytic Association,* Vol. 42(4), 1001-1025.

Steele, B. F. & Pollack, C. B. (1974). A psychiatric study of parents who abuse infants and small children. In R. E. Helfer and C. H. Kempe (eds.), *The Battered Child,* Chicago: University of Chicago Press.

Straus, M. (1980). Wife beating: how common is it? in M. S. Straus and G. T. Hotaling (eds.), *The Social Causes of Husband-Wife Violence.* Minneapolis: University of Minnesota Press.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry.* NY: W.W. Norton.

Sullivan, H. (1954). *The Psychiatric Interview.* NY: Borton.

Sullivan, H. S. (1956). *Clinical Studies in Psychiatry.* NY: W.W. Norton & co.

Thompson, R. A. (1996). *Counseling Techniques: Improving Relationships with Others, Ourselves, our Families, and our Environment.* Bristol, PA: Accelerated Development.

Thorndike, R., & Hagen, E. (1977). *Measurement and Evaluation in Psychology and Education.* (4th ed.). NY: Macmillan.

Thuesen, J. M., & Kroeger, O. (1988). *Type Talk - The 16 Personality Types That Determine How We Live, Love and Work.* NY: Tilden Press.

Tomlinson-Keasey, C. (1985). *Child Development.* Homewood, IL: Dorsey Press.

Trzepacz, P. & Baker, R. (1993). *The Psychiatric Mental Status Examination.* New York: Oxford University Press.

Turner, M. & Pinkston, R. (1993). Effects of a memory and aging workshop on negative beliefs of memory loss in the elderly. *Educational-Gerontology,* July-Aug. Vol. 19(5), 359-373.

Van Hoose, W. H. K., Jeffrey A. (1980). *Ethical & Legal Issues in Counseling and Psychotherapy.* San Francisco CA: Jossey Bass.

Vilch, M. A. (Ed.). (1979). *The Journal of Transpersonal Psychology.* (Vol. 11 #1). Stanford, CA: Journal of Transpersonal Psychology.

Walsh, B. (1993). Unpublished Communication, Workshop, Lynn, MA.

Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: implications for practice. *Professional Psychology:* Research & Practice, 24, 43-51.

Whitaker, C., and Napier, A. Y., (1988). *The Family Crucible.* NY: Harper Collins.

Whitmont, E. C., and Kaufmann, Y. (1973). In R. Corsini (ed.), *Current Psychotherapies.* Itasca, IL: F. E. Peacock Publishers, Inc.

Winchel, R. M. and Stanley, M. (1991). Self-injurious behavior: A review of the behavior and biology of self-mutilation. *American Journal of Psychiatry,* 148, 306-317.

Wolberg, L. R. (1965). *Short-Term Psychotherapy.* NY: Grune & Stratton.

Wolpe, J. (1958). *Psychotherapy by Reciprocal Inhibition.* Stanford CA: Stanford University Press.

Wolpe, J. (1973). *The Practice of Behavior Therapy.* NY: Pergamon Press.

Women's Crisis Center of Greater Newburyport. (1996). Unpublished Communication. Newburyport, MA.

Yost, E., & Corbishley, M. (1987). *Career Counseling: A Psychological Approach.* SF: Jossey Bass.

Zaro, J. S. (1977). *A Guide for Beginning Psychotherapists.* Cambridge MA: Cambridge University Press.

Zimmerman, D. R. (1994). *The Essential Guide to Non-Prescription Drugs.* NY: Harper & Row.

Zuckerman, E. (1993). *The Clinician's Thesaurus.* PA: Three Wishes Press.

Zunker, V. (1990). *Career counseling: Applied Concepts of Life Planning.* (3rd ed.). Pacific Grove CA: Brooks/Cole.

INDEX

A

Abandonment 248
Abuse 151
Abused children 153
Abusive Parents 151
Achievement tests 38
Adjustment Disorders 55, 73, 106
Adler 12
Adlerian Psychology 12
Age Factors 19
AIDS 256
Alcohol 62, 84, 169, 170, 198
Alcohol Screening Tools 170
Alcoholism 169
Amphetamine Use Disorder 62, 171
Amphetamines 200
Analytical Psychology 13, 116
Anastasi 21, 27, 29
Anna Freud 117
Anorexia 71, 101
Anticholinergic 189
Antidepressants 193
Antipsychotics 188
Anxiety Disorders 25, 54, 69
Anxiolytic Use Disorders 65, 181
Anxiolytics 191
Appraisal 21
Assessment 21, 22, 23, 24, 37, 38, 49, 52, 129, 163, 204
Assessment Interview 24

B

Bandura 6, 119, 148
Barbiturates 197
Battered women 154
Beck 21, 40, 118, 148, 156
Behavior Therapy 118
Behavioral Assessments 34
Bender Gestalt Test 31
Berne 120, 137
Blanck and Blanck 14
Bowlby 16
Brief treatment 147

C

Caffeine-Related Disorders 84, 172
California Psychological Inventory (CPI) 30
Cannabis 63, 84, 173, 202, 203
Career Assessment Instrument 38
Career Planning 229
Child Abuse and Neglect 151
Classical Conditioning 5, 118
Client variables 221
Clinical Notes 256
Clinical Report 48
Cocaine Abuse 63, 175
Cognitive Development Theories 5
Cognitive Therapy 118
Cognitive-Behavioral Therapy 118
Cognitive-Structural 5, 6
Concrete Operational Thought 7
Confidentiality 139, 240, 251
Conflict Resolution/Mediation 149
Consultive Models 241
Counseling Theories 115
Court Appearances 253
Crisis Intervention 148
Crites 236, 237

D

Danger to Others 251
Decision Making Models 232
Defense Mechanisms 10, 77
Delirium 54, 60, 78, 83
Delirium, Dementia, & Amnestic & Other Cognitive Disorders 54, 83
Denial 10
Dependence Syndrome 163
Diagnosis 25, 43, 52, 53, 56, 57, 76, 79, 80, 163, 164, 221
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence 54, 58, 81
Dissociative Disorders 55, 70
Domestic Violence 154
Drug Tolerance 187
DSM-IV 52, 53, 55, 58, 77, 78
Dual Diagnosis 87, 164
Dual Relationship 249
Durkheim 155
Duty to Warn 251

E

Eating Disorders 55, 59, 71, 82, 101, 102, 135
Ego-Psychology 117
Elder Abuse 255
Elderly 19
Elderly Populations 157
Ellis 118
Environment 3, 4, 5, 55, 149
Environmental-Learning 4, 5
Erikson 117
Existential Psychotherapy 120
Extrapyramidal Effects 190

F

Factitious Disorders 54, 69, 93, 94
Fairbairn 14
Family Assessments 35
Formal Operations 7
Freud 9, 18, 115

BEST COPY AVAILABLE

G

Gendlin 120
Geneograms 37, 130
Gestalt Therapy 119
Glasser 120
Gottfredson 233
Growth And Development 3, 7

H

Hallucinogen-Related Disorders 63, 84, 176
Hallucinogens 202
Hartman 117
Heredity 3
Holland 39, 234
Hoppock 235
Horner 14
Horney 12, 148
House Tree Person 34
Humanistic Therapies 119

I

Impulse-Control Disorders Not Elsewhere Classified 55
Incomplete Sentences Blank 34
Informed Consent 240, 250
Inhalant-Related Disorders 64, 84, 177
Instinctual drives 10
Intelligence 27, 48, 51
Interpersonal Psychotherapy 14

J

Jung 13, 116

K

Kernberg 14, 117
Kohlberg 15
Kohut 117

L

Language Development 7
Lazarus 118
Lesbian and Gay Clients 159
Levinson 19
Lichtenstein 117
Life-career rainbow 234
Lorenz 16
Luria Nebraska 31

M

Malpractice 248
Managed Care 148
MAO Inhibitors 195
Maslow 14, 15
Mental Disorder 54, 75, 84
Mental Disorders Due to a General Medical Condition 54, 61, 84
Mental Retardation 54, 55, 58, 77, 81
Mental Status 23, 25, 43, 45, 49, 163
Minnesota Multiphasic Personality Inventory (MMPI) 30
Minority Clients 158
Minors 253
Moderate and Long Term Therapy 148
Mood Disorders 54, 67, 68, 87
Mood Stabilizers 195
Moral Development 15
Multiaptitude Test 37
Multiaxial System 77
Myers-Briggs Type Indicator (MBTI) 31

N

Negligent Evaluation 248
Neo-Freudians *11, 116*
Nicotine Dependence 64, 178

O

Object Relations Theory 14
Operant Conditioning 5, 118
Opioid Use Disorder 179
Opioid-Analgesics 198
Organizational Consultation 239, 240
Orthostatic Hypotension 190

P

Parenting Styles 18
PCP 65, 84, 180, 202
Perls 119, 136
Perpetrators 154
Person-Centered Therapy 119
Personality and Social Development 9
Personality Disorders 54, 55, 74, 77, 107
Personality tests 29
Pharmacokinetics 186
Phencyclidine Use Disorders 65, 180
Physical Disabilities 158
Piaget 6
Polysubstance Abuse 182
Preoperational/Symbolic Thought 6
Prescription Drug Abuse 184
Prevention 225, 228
Privileged Communications 252
Professional Practice 245
Projective Tests 32
Psychoanalysis 115
Psychodynamic Psychotherapies 115
Psychopharmacology 185
Psychosocial Development 11

R

Rapaport 117
Rational Emotive Therapy 118
Reality Therapy 120
Reality therapy 106, 120
REBT 118
Record Keeping 256
Record Storage 257
Recrudescence 184
Referral 256
Research and Evaluation 205
Reverse Tolerance 162
Ritalin 201
Roe 235
Rogers 119
Rorschach 32

S

Schizophrenia and Other Psychotic Disorders 54, 66, 85
Scholastic Tests 38
Scope Of Practice 245
Sedatives-Hypnotics 196
Self Psychology 117
Self-Actualization theory 14
Self-Reports 40

Sensorimotor 6
Sex Role Development 17
Sexual and Gender Identity Disorders 55, 70, 78
Sixteen Personality Factor Questionnaire (16 PF) 31
Skinner 5, 118
Sleep Disorders 26, 55, 72, 102
Social Learning Theory 6
Somatoform Disorders 54, 69
Special Treatment Issues 151
Stages of Adulthood 19
Stages of Consultation 241
Stanford-Binet 27, 28
Statistics 211
Steps to Diagnosis 79
Strong-Campbell 39
Structured Family Interview 35, 36
Substance Abuse Disorders 161
Substance-Related Disorders 54, 61, 66, 84, 184
Suicide 155, 251
Sullivan 116
Super 233
Symptom rebound 183
Synergism 187

T

Test resources 23
Testing 27
Thematic Apperception Test (TAT) 33
Therapeutic Alliance 220
Therapist Variables 221
Transactional Analysis (TA) 120
Treatment Factors 222
Treatment Modalities 147, 166
Treatment Planning 23, 81, 204
Types of Statistics 211

U

Unprofessional Conduct 246
Useless treatment 249

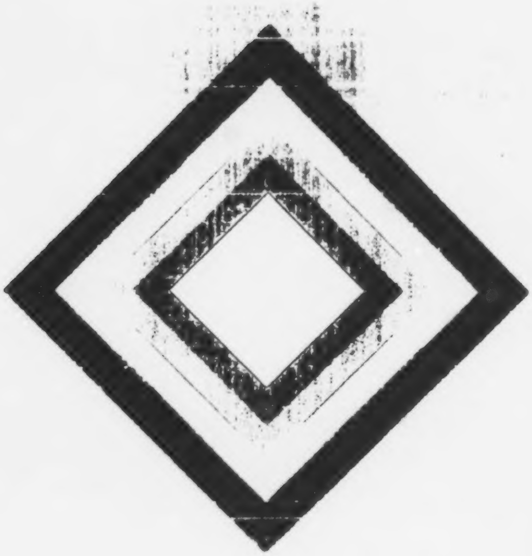
V

Values Assessment 37
Vicarious Liability 250

W

Wechsler Tests 27
Wiltwyck Family Task 35
Wolpe 118

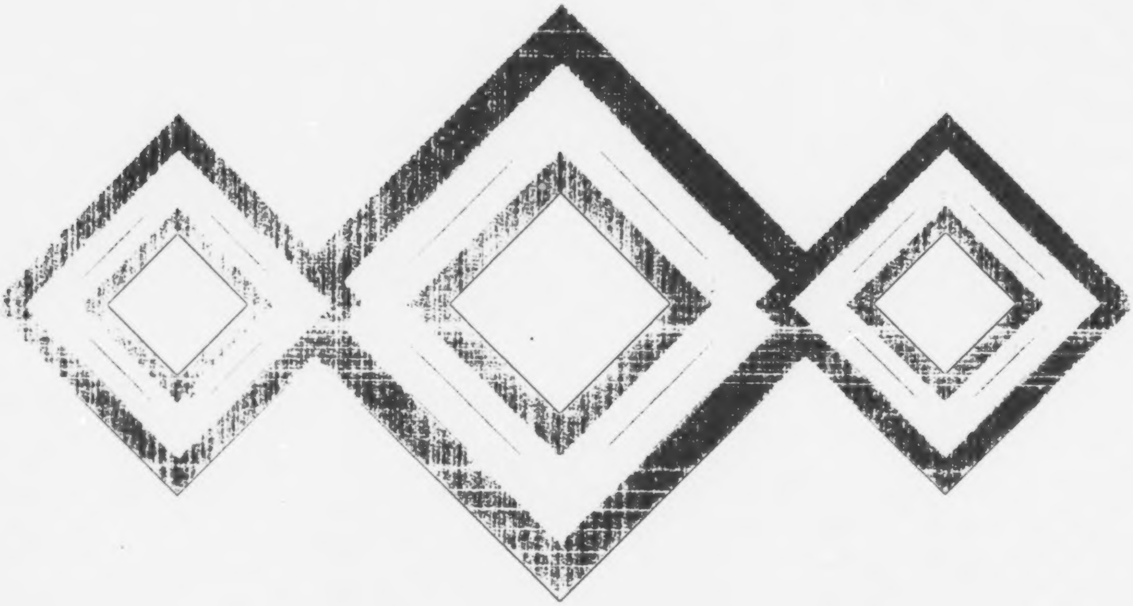
BEST COPY AVAILABLE



KENDALL/HUNT PUBLISHING COMPANY
Dubuque, Iowa 52002

ISBN 0-7872-6385-0

Assessment Questions



Bonnie Bullard, Ph.D., LMHC
Linda Lawless, M.A., LMFT, LMHC
Midge Williams, M.A., LMHC
with Deborah Bergstrom

Professional Training Institute
P.O. Box 393
Sudbury, MA 01776

American
Mental
Health
Counselors
Association

Mental Health Counselor's Clinical Practice Companion: A Continuing Education Program
Registration Form

Professional Training Institute
P.O. Box 393
Sudbury, MA 01776
617-576-8877 888-201-1619

American Mental Health
Counselors Association
801 N. Fairfax Street
Suite 304
Alexandria, VA 22314-1757

Correct Mark
●

Incorrect Mark
⊘ ⊠ ✓ ○

Marking Instructions

- Use a No. 2 pencil or blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the oval completely.
- Make no stray marks on this form.
- Do not fold, tear, or mutilate this form.

Please print information in boxes and fill in corresponding circles below.

Last Name	First Name	MI	Social Security Number
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐☐☐☐☐☐☐☐☐	☐	☐☐☐☐☐☐☐☐☐
Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ	Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ Ⓐ	Ⓐ	⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪
Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ	Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ Ⓑ	Ⓑ	① ① ① ① ① ① ① ① ①
Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ	Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ Ⓒ	Ⓒ	② ② ② ② ② ② ② ② ②
Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ	Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ Ⓓ	Ⓓ	③ ③ ③ ③ ③ ③ ③ ③ ③
Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ	Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ Ⓔ	Ⓔ	④ ④ ④ ④ ④ ④ ④ ④ ④
Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ	Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ Ⓕ	Ⓕ	⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤
Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ	Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ Ⓖ	Ⓖ	⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥
Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ	Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ Ⓗ	Ⓗ	⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦
Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ	Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ Ⓘ	Ⓘ	⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧
Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ	Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ Ⓙ	Ⓙ	⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨
Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ	Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ Ⓚ	Ⓚ	
Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ	Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ Ⓛ	Ⓛ	
Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ	Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ Ⓜ	Ⓜ	
Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ	Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ Ⓝ	Ⓝ	
Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ	Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ Ⓞ	Ⓞ	
Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ	Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ Ⓟ	Ⓟ	
Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ	Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ Ⓠ	Ⓠ	
Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ	Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ Ⓡ	Ⓡ	
Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ	Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ Ⓢ	Ⓢ	
Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ	Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ Ⓣ	Ⓣ	
Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ	Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ Ⓤ	Ⓤ	
Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ	Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ Ⓥ	Ⓥ	
Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ	Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ Ⓦ	Ⓦ	
Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ	Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ Ⓧ	Ⓧ	
Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ	Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ Ⓨ	Ⓨ	
Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ	Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ Ⓩ	Ⓩ	

000045

62595

Street Number/Name

City

State

Zip Code

Telephone Number

Upon completion, please return your Answer Sheet and your Registration Form in the enclosed envelope and afix proper postage

000045

62595

Mental Health Counselor's Clinical Practice Companion: A Continuing Education Program
Answer Sheet

Name____________________________________

Address____________________________________

City____________________________________

State/Zip____________________________________

Telephone____________________________________

Social Security Number

☐☐☐☐☐☐☐☐☐

⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪ ⓪
① ① ① ① ① ① ① ① ①
② ② ② ② ② ② ② ② ②
③ ③ ③ ③ ③ ③ ③ ③ ③
④ ④ ④ ④ ④ ④ ④ ④ ④
⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤ ⑤
⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥ ⑥
⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦ ⑦
⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧ ⑧
⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨ ⑨

Please print name and social security number to insure proper crediting.

Growth and Development

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ

Personality and Social Development

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ

Assessment

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ

Diagnosis

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ
17 Ⓐ Ⓑ Ⓒ Ⓓ
18 Ⓐ Ⓑ Ⓒ Ⓓ
19 Ⓐ Ⓑ Ⓒ Ⓓ
20 Ⓐ Ⓑ Ⓒ Ⓓ
21 Ⓐ Ⓑ Ⓒ Ⓓ
22 Ⓐ Ⓑ Ⓒ Ⓓ
23 Ⓐ Ⓑ Ⓒ Ⓓ
24 Ⓐ Ⓑ Ⓒ Ⓓ
25 Ⓐ Ⓑ Ⓒ Ⓓ
26 Ⓐ Ⓑ Ⓒ Ⓓ

Treatment Planning

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ

Counseling Theories

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ

Family Therapy

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ
17 Ⓐ Ⓑ Ⓒ Ⓓ
18 Ⓐ Ⓑ Ⓒ Ⓓ
19 Ⓐ Ⓑ Ⓒ Ⓓ
20 Ⓐ Ⓑ Ⓒ Ⓓ
21 Ⓐ Ⓑ Ⓒ Ⓓ
22 Ⓐ Ⓑ Ⓒ Ⓓ
23 Ⓐ Ⓑ Ⓒ Ⓓ

Group Therapy

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ

Special Treatment Issues

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ

Substance Abuse

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ
17 Ⓐ Ⓑ Ⓒ Ⓓ
18 Ⓐ Ⓑ Ⓒ Ⓓ
19 Ⓐ Ⓑ Ⓒ Ⓓ
20 Ⓐ Ⓑ Ⓒ Ⓓ
21 Ⓐ Ⓑ Ⓒ Ⓓ
22 Ⓐ Ⓑ Ⓒ Ⓓ
23 Ⓐ Ⓑ Ⓒ Ⓓ

Psychopharmacology

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ
17 Ⓐ Ⓑ Ⓒ Ⓓ
18 Ⓐ Ⓑ Ⓒ Ⓓ
19 Ⓐ Ⓑ Ⓒ Ⓓ
20 Ⓐ Ⓑ Ⓒ Ⓓ

000045

9161

Research and Statistics

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ

Outcome Studies

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ

Prevention

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ

Career Development

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ

Organizational Consulting

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ

Professional Practice

1 Ⓐ Ⓑ Ⓒ Ⓓ
2 Ⓐ Ⓑ Ⓒ Ⓓ
3 Ⓐ Ⓑ Ⓒ Ⓓ
4 Ⓐ Ⓑ Ⓒ Ⓓ
5 Ⓐ Ⓑ Ⓒ Ⓓ
6 Ⓐ Ⓑ Ⓒ Ⓓ
7 Ⓐ Ⓑ Ⓒ Ⓓ
8 Ⓐ Ⓑ Ⓒ Ⓓ
9 Ⓐ Ⓑ Ⓒ Ⓓ
10 Ⓐ Ⓑ Ⓒ Ⓓ
11 Ⓐ Ⓑ Ⓒ Ⓓ
12 Ⓐ Ⓑ Ⓒ Ⓓ
13 Ⓐ Ⓑ Ⓒ Ⓓ
14 Ⓐ Ⓑ Ⓒ Ⓓ
15 Ⓐ Ⓑ Ⓒ Ⓓ
16 Ⓐ Ⓑ Ⓒ Ⓓ
17 Ⓐ Ⓑ Ⓒ Ⓓ
18 Ⓐ Ⓑ Ⓒ Ⓓ
19 Ⓐ Ⓑ Ⓒ Ⓓ
20 Ⓐ Ⓑ Ⓒ Ⓓ

Upon completion, please return your Answer Sheet and your Registration Form in the enclosed envelope and affix proper postage

9161

000045

MENTAL HEALTH COUNSELOR'S CLINICAL PRACTICE COMPANION

◆ ◆ ◆

A Continuing Education Program

Assessment Questions

Bonnie Bullard, Ph.D., LMHC
Linda Lawless, M.A., LMFT, LMHC
Midge Williams, M.A., LMHC
and Deborah Bergstrom

Professional Training Institute
PO Box 393
Sudbury, MA 01776
617-576-8877 • 888-201-1619

AMHCA
American
Mental
Health
Counselors
Association

KENDALL/HUNT PUBLISHING COMPANY
4050 Westmark Drive Dubuque, Iowa 52002

Copyright © 1999 by Professional Training Institute

ISBN 0-7872-6386-9

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the copyright owner.

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

BEST COPY AVAILABLE

THIS HOME-STUDY PROGRAM CONTAINS:

- ***Mental Health Counselor's Clinical Practice Companion***
  (the text)
- A self-examination
  (to assess learning strengths and weaknesses, and to obtain CE credit)
- A study log
  (to plan your home study program and certify your work on the program)
- A program evaluation
  (to be returned with your examination)
- A pre-addressed return envelope
  (to submit your examination for scoring and credit)

Please check to see that all of these items are included in your program. If any part is missing, contact Kendall/Hunt Publishing Company, AMHCA, or PTI and we will send you the missing part immediately at no cost to you.

HOW TO USE THIS STUDY PROGRAM

We recommend you begin with the chapters that are of greatest interest to you. Study the chapter and answer the questions on the examination. The exam groups the questions by chapter, which makes it easy to coordinate with chapter review. Record your study dates and times on the Study Log. You can also use your study log as a goal setting tool. When you receive the program set a goal date for when you plan on completing that chapter. Mark this date on your personal/professional calendar to remind yourself that it is due. Commit to studying one chapter a week. Plan to complete the program within seventeen weeks or less.

When you have completed the study program, send all of the following in the enclosed pre-addressed return envelope:

___ Your examination
___ Your signed study log
___ Your course evaluation

IMPORTANT INFORMATION

1. Your exam will be scored and the results mailed to you within 12 weeks.
2. You have a year to complete the program. If you do not complete the program within a year you will need to contact AMHCA to extend your completion dates.

BEST COPY AVAILABLE

3. If your exam score is below the passing score you will be notified of the score you received and the passing score required (70%). At that time you will have the opportunity to take a second assessment examination. There will be a $50.00 administration fee.
4. Once you have passed the examination you will be sent a continuing education certificate from AMHCA with your name, the date of your passing score, and the number of hours received for this program. (20 CEUs)

Growth and Development

1. Bruner's stage where a child learns about the world through actions.
   a. Concrete Operations b. Sensorimotor c. Enactive d. Adaptation

2. The source of unconscious motives and drives according to Freud.
   a. Libido b. Id c. Archetype d. Subconscious

3. The mechanism of rejecting anxiety provoking thoughts and/or feelings from consciousness is called _____.
   a. Thought Stopping b. Repression c. Avoidance d. Projection

4. The stage of development focusing on social skills is _____.
   a. Conventional b. Latency c. Iconic d. Adaptational

5. The stage wherein reasoning is based on logic is referred to as _____.
   a. Symbolic b. Cognitive-structural
   c. Formal Operations d. Concrete Operations

6. Preconventional, Conventional & Postconventional refer to _____.
   a. Stages of development b. Levels of morality
   c. Levels of adaptation d. All of the above

7. The primary bond between an infant and its primary caretaker is referred to as _____.
   a. Object Relations b. Love c. Imprinting d. Attachment

8. Piaget postulates _____ as the primary organizing force underlying behavior.
   a. Adaptation b. Equilibration c. Assimilation d. Accommodation

9. The primary mediating structure of the personality is called the _____.
   a. Real Self b. Ego c. Archetype d. Superego

10. The incorporation of new knowledge into existing structures is called _____.
    a. Assimilation b. Accommodation c. Identification d. Re-framing

11. The _____ is the particular time frame in which experience has the greatest impact on human development.
    a. First year b. Oral stage c. Critical period d. Sensorimotor

12. The refusal to see something which is a fact or true in reality refers to the process of _____.
    a. Denial b. Avoidance c. Rationalization d. Blocking

13. The _____ is the official mask or pattern of behavior that a person uses in social situations.
    a. Shadow b. Persona c. False self d. Felt self

14. The type of anxiety that begins at about 1 year of age is _____.
    a. Separation b. Stranger c. Pre-cursive d. Detachment

15. _____ is opposed to shame and doubt in Erikson's theory of development.
    a. Trust b. Initiative c. Integrity d. Autonomy

Personality and Social Development

1. The therapist who created the idea of the collective unconscious was _____.
    a. Maslow b. Jung c. Freud d. Adler

2. Cognitive restructuring is a technique used in _____.
    a. Rational Emotive Therapy (RET) b. Transactional Analysis (TA)
    c. Realty Therapy d. Gestalt Therapy

3. Internal conflicts form the basis of personality in _____ theory.
    a. Existential b. Cognitive Behavioral c. Psychodynamic d. Transactional

4. The theorist who holds the greatest similarity of viewpoint with Freud is _____.
    a. Jung b. Sullivan c. Kohut d. Horney

5. Conditioning and learning are fundamental concepts of this theory.
    a. Social Learning Theory b. Behaviorism c. RET d. All of the above

6. The theorist that believes we start out life small, weak and powerless is _____.
    a. Adler b. Freud c. Sullivan d. Kernberg

7. According to Freud, our primitive selfish aspects are found in the _____.
    a. Subconscious b. Id c. Superego d. Anal stage

8. Self actualization refers to persons making full use of their _____.
    a. Personality b. Potential c. Self awareness d. Peak Experiences

9. According to Freud, aggressive urges are the result of lack of development of the _____.
    a. Superego b. Instinctual Drives c. Drive Conflict d. Psyche

10. According to Adler, the human capacity to create one's own personality supports _____.
    a. Generativity b. Self actualization c. Becoming d. Life script

11. A key concept of Roger's personality theory is _____.
    a. Congruence b. Positive regard c. Growthful change d. All of the above

12. In psychoanalytic theory conscious control is experienced by the _____.
    a. Ego b. Superego c. Actual self d. Personality

13. One of two of Freud's motivational instincts is the _____.
    a. Libido b. Id c. Anima d. Animus

14. This theorist perceived people as being selfish, impulsive and irrational.
    a. Freud b. Erikson c. Kohlberg d. Bowlby

15. Learning sex appropriate behavior is influenced by identification and _____.
    a. Moral development b. Assimilation c. Accommodation d. Imitation

Assessment

1. The assessment process begins with the _____ of the potential client.
   a. Pyschosocial history b. First contact c. Mental Status d. Diagnosis

2. Case management includes _____.
   a. Assessment tools b. Intervention techniques
   c. Treatment approaches d. All of the above

3. In treatment planning the severity of a problem can be measured with the _____.
   a. BSI b. Stages of Change Scale
   c. DSM-IV multi-axial assessment d. TAT

4. Phase 2 of the assessment interview focuses on _____.
   a. Mental Status b. Symptoms c. Diagnosis d. Personal history

5. An intelligence test that measures children's intelligence ages 4 years to 6 1/2 years is the _____.
   a. WAIS-R b. Stanford Binet-C c. WPPSI d. WISC-R

6. An intelligence test used for the physically handicapped is the _____.
   a. Porteus Maze Test b. Kaufman Assessment Battery
   c. Raven's Progressive Matrices d. Piagetian Scales

7. A popular personality assessment tool that includes validity scales is the _____.
   a. MIPS b. 16PF c. MMPI d. MCMI

8. Raymond Cattell developed this personality assessment tool that proposes to measure the whole of human personality:
   a. 16PF b. ICL c. MCMI d. CPI

9. The _____ is a classification of projective tests in which an individual develops a response to a situation.
   a. Association technique b. Construction technique
   c. Completion technique d. Expressive technique

10. The Rorschach projective test is classified as a _____ technique test.
    a. Association b. Interpretive c. Expressive d. Completion

Diagnosis

1. Sudden, rapid stereotyped motor and vocal tics characterize this disorder.
   a. Paraphillia b. Pica c. Tourettes d. Rumination

2. The elimination of urine at inappropriate times and/or places is _____.
   a. Bedwetting b. Encopresis c. Enuresis d. Retts Syndrome

3. This mood disorder is characterized by dramatic mood swings.
   a. Episodic Hypomania b. Bipolar c. Cyclothymia d. Schizoaffective

4. Depressed mood, eating and sleep disturbances, low self-esteem, and low energy for two years are the defining symptoms of _____.
   a. Major Depression b. Narcolepsy c. Eating Disorder NOS d. Dysthymia

5. Stereotyped behavior, interests and activities, with pervasive impairment in social and speech skills characterize this disorder.
   a. Schizoid b. Autism c. Tourettes d. Retts Syndrome

6. The elimination of feces at inappropriate times and/or places is _____.
   a. Encopresis b. Enuresis c. FED d. None of the above

7. Disorders of memory impairment are called _____.
   a. Dementia b. Delirium c. Amnestic d. Alzheimer's Disease

8. Hyperactivity, impulsivity, disorganization, and poor focusing are all features of _____.
   a. ADHD b. Reactive Attachment Disorder
   c. Transient Hyperactivity d. Tourettes

9. The class of disorders with marked impairment in reality testing and social and occupational functioning is _____.
   a. Dissociative Disorder b. Schizoid Disorder
   c. Cognitive Disorders d. Schizophrenia

10. Schizophrenic symptoms combined with a major mood disorder is called _____.
    a. Schizophreniform Disorder b. Schizoaffective Disorder
    c. Depressive Cognitivized Disorder d. Undifferentiated Schizophrenia

11. This disorder can be diagnosed as a personality disorder or a psychotic disorder.
    a. Shared Psychotic Disorder b. Schizoid Disorder
    c. Schizotypal Disorder d. Paranoid Disorder

12. The extreme need for admiration, grandiosity, and the lack of empathy characterize persons diagnosed as _____.
    a. Sociopathic b. Narcissistic c. Schizotypal d. Histrionic

13. Disorders wherein actual or perceived symptoms are not explained by a general medical condition are called _____.
    a. Conversion Disorders b. Somatization Disorders
    c. Somatoform Disorders d. Somatic Psychoses

14. _____ is a dyssomnia.
    a. Catatonia b. Narcolepsy c. Parasomnia d. Bulimia

15. Individuals showing disruptions of the integrative functions of memory, consciousness, and identity are diagnosed with a _____ disorder.
    a. Dissociative b. Psychotic c. Schizophrenic d. Narcissistic

16. This disorder is characterized by extreme social inhibition, feelings of inadequacy, and fear of a negative evaluation.
    a. Schizoaffective b. Avoidant c. Social Phobia d. None of the above

17. Clinically significant emotional or behavioral symptoms that appear in response to a specific stressor are diagnosed as a _____.
    a. Reactive Disorder b. Adjustment Disorder
    c. Major Depression d. Dysthymic Disorder

18. Impulsivity and instability in relationships, self-image and affect characterize persons diagnosed with _____ disorder.
    a. Schizophreniform b. Histrionic c. Borderline d. Impulse Disorder NOS

19. Recurrent or persistent genital pain associated with sexual intercourse that is not due to a medical condition is called _____.
    a. Trichotillomania b. Vaginismus c. Phenylkaptineuria d. Dyspareunia

20. Persons diagnosed as having a _____ disorder exhibit eccentricity, great discomfort in social relationships and distortions.
    a. Schizotypal b. Social Phobia c. Avoidant d. Borderline

21. Intentionally produced or feigned physical or psychological symptoms are symptoms of _____.
    a. Malingering b. Hypochondriasis
    c. Conversion Disorder d. Factitious Disorder

22. Binge eating and inappropriate compensatory behavior are symptoms of _____.
    a. Anorexia with purging b. Bulimia c. Eating Disorder NOS d. Pica

23. The disorder characterized by pervasive and excessive emotionality and attention seeking behavior is _____.
    a. Histrionic b. Narcissistic c. Borderline d. Schizoaffective

24. The disorder characterized by detachment from social relationships and severely restricted emotional expression is called _____.
    a. Schizoid b. Schizoaffective c. Schizotypal d. Avoidant

25. The diagnosis of _____ refers to the refusal to maintain a minimal body weight.
    a. Bulimia b. Anorexia with purging
    c. Anorexia d. Eating Disorder NOS

26. A schizophrenic disorder with marked psychomotor disturbance is _____.
    a. Paranoid type b. Schizotypal c. Somatic type d. Catatonic type

Treatment Planning

1. Treatment for this condition almost always includes the client and family.
    a. Mental Retardation b. ADHD c. Bi-polar Disorder d. Bulimia

2. Axis II disorders are generally harder to treat because they are considered _____.
    a. Vegetative b. Hypomanic c. Psychotic d. Ego syntonic

3. Disorders where a "package plan" is most effective in treatment.
    a. Parasomnias b. Eating Disorders
    c. Substance related d. Generalized Anxiety Disorders

4. A type of disorder where treatment includes exploration of original trauma is _____.
    a. Bulimia b. Dissociative c. Obsessive compulsive d. Schizoaffective

5. Medication is the primary mode of treatment for _____.
    a. PTSD b. Dyspaneuria c. Schizophrenia d. Anorexia

6. The personality group for which initial treatment must be especially careful and deliberate is the _____ group.
    a. Histrionic Emotive b. Fearful Anxious
    c. Indirect Passive d. Odd Eccentric

7. Persons with personality disorders are often _____ in treatment.
    a. Hostile b. Resistant c. Anxious d. Briefly

8. The personality group that is most resistant to treatment is the _____ group.
    a. Indirect Passive b. Anxious Fearful
    c. Dramatic Emotional d. Odd Eccentric

9. Clients with a _____ disorder should be followed closely by both a neurologist and psychiatrist.
    a. Cognitive b. Dissociative c. Eating d. Factitious

10. Psychotherapy with medication is indicated when a _____ is severe.
    a. Fugue State b. Factitious Disorder
    c. Mood Disorder d. Personality Disorder

11. A combination of behavioral and cognitive treatment is especially helpful with _____.
    a. Impulse Control Disorders b. Anxiety Disorders
    c. Eating Disorders d. Sleep Disorders

12. This treatment is often used with sleep disorders.
    a. Biofeedback b. Medication c. Group Therapy d. Reality Therapy

13. Treatment issues that are especially important with disorders due to a medical condition include _____.
    a. Medication b. Relational c. Substance Related d. Loss

14. The type of disorder in which the therapist helps clients find new resources and supports is called _____.
    a. ADHD b. Mental Retardation c. Dysthymia d. Adjustment

15. Group treatment with a strong leader can be helpful in treating _____.
    a. Bipolar Disorder b. Eating Disorders
    c. Somatoform Disorders d. Personality Disorders

16. In treating _____ disorders the therapist and physician must work closely together.
    a. Anxiety b. Substance Abuse c. Somatoform d. Obsessive Compulsive

Counseling Theories

1. In psychoanalysis the re-stating of a client's statements and feelings is called _____.
   a. Working through b. Clarification c. Catharsis d. Confrontation

2. _____ is the technique that explicitly connects present behavior to unconscious conflicts and processes.
   a. Insight b. Clarification c. Interpretation d. Chaining

3. Life interactions based on early childhood beliefs about self and others are called _____.
   a. Self-awareness b. Narcissism c. Felt sense d. Scripts

4. This type of therapy emphasizes empirical evaluation of thought patterns.
   a. Cognitive b. Transactional Analysis
   c. Thought Processing d. Psychodynamic

5. The psychotherapeutic theory of H. S. Sullivan is called _____.
   a. Client Centered b. Sullivanian c. Interpersonal d. Humanistic

6. The theory where the psyche is a self-regulating system with dynamic interplay between conscious and unconscious is referred to as _____.
   a. Self-psychology b. Analytic c. Reality Therapy d. Gestalt

7. _____ is a type of therapy where irrational beliefs are disputed and challenged.
   a. Rational Emotive b. Confrontational c. Existential d. Logical Analysis

8. The classical conditioning procedure for reducing anxiety is called _____.
   a. Anxiety Reduction b. Relaxation c. Desensitization d. Clarification

9. The primary focus of Gestalt therapy is _____.
   a. Integration b. Here and Now
   c. Increased Self-esteem d. Peak Experience

10. This type of therapy equates personal responsibility for behavior with mental health.
   a. Self psychology b. Transactional Analysis
   c. Client Centered d. Reality Therapy

Family Therapy

1. In couples work, when one partner acts immaturely, but both are immature, it is called _____.
   a. Accommodation b. Emotional Divorce
   c. Equifinality d. Marital schism

2. A family regulatory system is referred to as _____.
   a. Calibration b. Accommodation c. Homeostasis d. All of the above

3. _____ is the tendency for any system to react toward the restoration of the status quo.
   a. Accommodation b. Homeostasis c. Calibration d. Wholeness

4. _____ refers to the same results springing from different causes.
   a. Homeostasis b. Positive feedback c. Equifinality d. Calibration

5. _____ is an accommodation technique of providing family support.
   a. Conjoint family therapy b. Mimesis c. Tracking d. Maintenance

6. Behaviors that restore the family comfort zone are called _____.
   a. Negative feedback b. Positive feedback
   c. Joining d. Conjoint family therapy

7. When each part of the system is related to its fellow parts it is called _____.
   a. Wholeness b. Homeostasis c. Joining d. Undifferentiated family ego

8. When the family meets the needs of one member of the family at the expense of others it is called a _____.
   a. Marital schism b. Marital contract c. Double bind d. Marital Skew

9. When the whole is equal to more than the sum of its parts it is called _____.
   a. Equifinality b. Non Summativity c. Wholeness d. None of the above

10. Chronic discord and disequilibrium between parents is referred to as _____.
    a. Marital Skew b. Negative Feedback
    c. Emotional Divorce d. Marital Schism

11. _____ is often called the grandfather of family therapy.
    a. Bowen b. Bell c. Ackerman d. Haley

12. The founder of Structural Family Therapy is _____.
    a. Wynne b. Jackson c. Minuchin d. Haley

13. _____ coined the term "marital skew".
    a. Wynne b. Lidz c. Minuchin d. Bell

14. _____ coined the term "family ego mass".
    a. Haley b. Bell c. Bowen d. Minuchin

15. Which of these family therapists insists on the use of co-therapists?
    a. Whitaker b. Lidz c. Haley d. Ackerman

16. Which theorist is thought to be the first to apply systems thinking to family therapy?
    a. Watzlawic b. Jackson c. Framo d. Zuk

17. _____ considers any relationship as a power struggle.
    a. Satir b. Whittaker c. Haley d. Zuk

18. Which family therapist created definitions of "family games"?
    a. Satir b. Haley c. Minuchin d. Zuk

19. _____ uses a triadic-based approach in working with families.
    a. Bell b. Bowen c. Ackerman d. Zuk

20. A clinician who promotes interaction using a star-shaped verbal communication pattern is called a _____.
    a. Coach b. Family therapist c. Conductor d. Co-therapist

21. The Bowenian characterization of the therapist's role is a _____.
    a. Coach b. Conductor c. Co-therapist d. Family therapist

22. When the family structure is very fragile it is a _____ to do family therapy.
    a. Good idea b. Strengthening process c. Contraindication d. First step

23. A multi-generational visual picture of a family is called a _____.
    a. Family sculpture b. Genogram c. Sociogram d. Family tree

Group Therapy

1. _____ created the theater of spontaneity.
   a. Bell b. Moreno c. Yalom d. Erickson

2. _____ listening is a kind of listening that communicates to the other that they have been heard.
   a. Reflective b. Dynamic c. Active d. Supportive

3. An intervention that ends counter productive behaviors is called _____.
   a. Limit setting b. Blocking c. Re-direction d. Termination

4. Being able to freely express feelings is referred to as _____
   a. Rational Emotive Therapy b. Abreaction c. a Gestalt d. Catharsis

5. Focusing on underlying issues and getting a clear picture of a situation is called _____.
   a. Clarifying b. Psychodynamic c. Reductionism d. FUI

6. Challenging others in a direct way is called _____.
   a. Assertive Communication b. Confrontation
   c. Rational Emotive d. Conflict Resolution

7. Sensing the subjective world of others is called _____.
   a. Intuition b. Empathy c. Enngraming d. Gestalt

8. _____ is the process of helping others clarify goals.
   a. Coaching b. Group Therapy c. Facilitating d. Clarifying

9. The concept of _____ refers to looking for themes and connecting them.
   a. Linking b. Facilitating c. Archetyping d. Psychotherapy

10. This theorist was a proponent of client centered groups.
    a. Ellis b. Rogers c. Perls d. Moreno

11. Yalom's first group stage is _____.
    a. Storming b. Forming c. Initiation d. Orientation

12. An awareness of emotions previously blocked from consciousness is called _____.
    a. Catharsis b. Abreaction c. Empathy d. Insight

13. _____ occurs when group members begin to share feelings .
    a. Norming b. Conflict c. Performing d. Cohesion

14. When several members of a group align against an individual it is called _____.
    a. Scapegoating b. Blocking c. Triangulation d. All of the above

15. When group members find that others share their conflicts it is called _____.
    a. Forming b. Mutuality c. Cohesion d. Orientation

Special Treatment Issues

1. This type of behavior is sometimes exhibited by abused children.
   a. Antisocial b. Withdrawal c. PTSD d. All of the above

2. A child victim of _____ is more seriously affected than other types of trauma victims.
   a. Physical abuse b. Emotional abuse c. Sexual abuse d. Incest

3. Respect for these clients is especially important in their psychotherapy.
   a. Girls b. Parents c. Elderly d. Adolescents

4. This type of play is seen more in abused children.
   a. Immature b. Disorganized c. Sexualized d. Antisocial

5. Abused children suffer more than other children of from _____.
   a. Aggression b. Low self-esteem c. Distractibility d. Dependency

6. _____ can be a characteristic of abusive parents.
   a. Social isolation b. Depression c. Anxiety d. Sleep disturbances

7. The treatment modality used for suicidal clients is _____.
   a. "Tough love" b. Team c. Contracting d. Reality therapy

8. The absence of role models is difficult for this client group.
   a. Disabled clients b. Elderly clients c. Gay clients d. Minority clients

9. _____ can appear charming and affable outside of home.
   a. Suicidal clients b. Sexual abuse perpetrators c. Batterers d. PTSD clients

10. No definitive way of predicting _____ has been found.
    a. Suicide b. Battering c. Sexual abuse d. Incest

Substance Abuse

1. The need for more of a substance to achieve similar results is called _____.
   a. Abuse b. Persistence c. Tolerance d. Dependence

2. A reversible syndrome that is substance specific is called _____.
   a. Dependency b. Intoxication c. Abuse d. Dependence Syndrome

3. It is often difficult to develop a therapeutic relationship with the abuser of this substance.
   a. Cannabis b. Alcohol c. Cocaine d. Inhalants

4. The _____ arena supports early substance use.
   a. Cultural b. Educational c. Social d. Family

5. The first most difficult issue to address in the treatment of substance abuse is _____.
   a. Withdrawal b. Denial c. Dependence d. Intoxication

6. _____ can produce psychoactive effects that can be life threatening.
   a. Alcohol use b. Inhalant use
   c. Cocaine use d. Amphetamine use

7. The use of a substance to relieve or avoid withdrawal symptoms is called _____.
   a. Substance abuse b. Addiction
   c. Persistence d. Substance intoxication

8. A therapeutic intervention used with hallucinogen users is _____.
   a. Psychotherapy b. Group therapy c. Aversive therapy d. Talk down

9. Using a substance for longer than intended is called _____.
   a. Persistence b. Abuse c. Intoxication d. Dependence

10. _____ is the first stage of treatment with substance abuse.
    a. Detoxification b. Pre-contemplation
    c. Preparation d. Deal with spiritual issues

11. A definition of _____ presumes no prior diagnosis of dependence.
    a. Tolerance b. Reverse tolerance c. Abuse d. Persistence

12. Methadone is used as an intervention for _____ use disorder
    a. Sedative b. Hypnotic c. Cocaine d. Opioid

13. These substance abuse patients are often severely and chronically mentally ill.
    a. Hallucinogen abusers b. Dual diagnosis patients
    c. Polysubstance abusers d. Heroin abusers

14. _____ is a substance that is easily abused that many people consume daily.
    a. Food b. Nicotine c. Caffeine d. Alcohol

15. A vitamin used in treatment of alcoholics is _____.
    a. Thiamin b. B12 c. B6 d. Folic Acid

16. A maladaptive pattern in relation to a substance that leads to clinically significant impairment or distress is called _____.
    a. Substance Abuse b. Substance Dependence c. Pre-abuse d. Relapse

17. The _____ syndrome is assessed using a scale that includes symptoms.
    a. Dependence b. Abuse c. Persistence d. Tolerance

18. A self report questionnaire used with alcohol abuse is _____.
    a. WISC b. 16PF c. CAGE d. MMPI

19. The stage of change that includes acknowledgment of personal responsibility with minimal willingness to change is referred to as _____.
    a. Preparation b. Contemplation c. Pre-contemplation d. Relapse

20. An aversive treatment used to treat alcohol abuse is _____.
    a. Imipramine b. Methadone c. Disulfiram d. Benzodiazepines

21. In treatment of the Flashback Syndrome _____ is commonly used as an intervention.
    a. Reassurance b. Anxiety relief c. Anxiolytics d. All of the above

22. When a drug is withdrawn and symptoms briefly reappear it is referred to as _____.
    a. Relapse b. Symptom rebound c. Withdrawal d. Paradoxical effect

23. When a symptom reemerges and remains after treatment is completed it is referred to as _____.
    a. Paresthesias b. Relapse c. Recrudescence d. Symptom Rebound

Psychopharmacology

1. Barbiturates, alcohol and opiates are all considered _____.
   a. Synergistic b. To have marked tolerance
   c. Sedatives d. Psychodynamic

2. A reduced response to a drug resulting from repetitive use is called _____.
   a. Reverse tolerance b. Tolerance
   c. An anticholinergic response d. An adverse reaction

3. Anti-anxiety agents are often referred to as _____.
   a. Anticholinergics b. CNS inhibitors c. TCAs d. Anxiolytics

4. The medication _____ affects the renal system and needs to be closely monitored.
   a. Morphine b. Librium c. Lithium d. Phenobarbital

5. A compulsive need to use a drug is called _____.
   a. Substance abuse b. Dependence c. Tolerance d. OCD

6. _____ are considered CNS stimulants.
   a. Amphetamines b. Anxiolytics c. Tetracyclics d. Tricyclics

7. The process by which a drug is distributed in the body is called _____.
   a. Pharmacodynamics b. Synergistic response c. DLT d. Pharmacokinetics

8. The process in which a drug begins its effects at its action site is _____.
   a. Pharmacokinetics b. Pharmacodynamics c. Synergistic response d. DLT

9. The increase of the effect of a substance combined with another is called _____.
    a. Orthostatic response b. Synergism
    c. Pharmacodynamics d. Pharmacokinetics

10. When the autonomic nervous system is affected it is called a/an _____.
    a. Anticholinergic reaction b. CNS disrupter
    c. Psychomotor agitation d. Delusion

11. When an abnormally low blood pressure results from standing one is considered to have _____ hypotension
    a. Pyschomotor b. Distonic c. Orthostatic d. Tardive

12. The inability to remain seated is called _____.
    a. Akathisia b. Tinitus c. Hypotension d. Tardive Diskenisia

13. Lack of muscle tone is referred to as _____.
    a. Flaxia b. Dystonia c. Diskinesia d. Ataxia

14. A small amount of alcohol with a modest dose of _____ can be lethal.
    a. Anti-depressants b. Mood Stabilizers c. Opiates d. Barbiturates

15. _____ is a natural opioid.
    a. Morphine b. Heroin c. Methadone d. Demerol

16. _____ is a pure synthetic opioid.
    a. Codeine b. Methadone c. Heroin d. Morphine

17. _____ is a syndrome often treated with amphetamines.
    a. OCD b. Dysthymia c. ADHD d. Bulimia

18. This substance was once used as a cure for Heroin addiction.
    a. Morphine b. Cannabis c. Opium d. Cocaine

19. A reaction sometimes resulting from use of hallucinogens is _____.
    a. TDs b. Disphoria c. Flashbacks d. Cataplexy

20. The psychoactive ingredient in Cannabis is _____.
    a. THC b. TCH c. HOOCH d. PCP

Research and Statistics

1. The measure of variability indicating how scores differ from one another is the _____.
    a. Correlation b. Mean c. Scatter d. Variance

2. The balance point of a set of scores is the _____.
    a. Median b. Percentage c. Mean d. Mode

3. _____ refers to the method used to select subjects for research.
    a. Variability b. Reliability c. Controls d. Sampling

4. The type of scale where information is ranked greatest to least is _____.
    a. Ordinal b. Nominal c. Integral d. Ratio

5. The hypothesis stating that no relationship exists between variables is called the _____ hypothesis.
    a. Ex post facto b. Descriptive c. Null d. Parametric

6. The measure of variability in relation to the mean is the _____.
    a. t-score b. Chi Square c. Range d. Standard deviation

7. The score occurring most often in a set of data is the _____.
    a. Mode b. Median c. Mean d. z-score

8. The simplest measure of variability, subtracting lowest score from highest, is the _____.
    a. Standard deviation b. Range c. t-score d. Variance

9. The score that divides a set of data in half is the _____.
    a. Median b. z-score c. Pearson R d. Mean

10. The most commonly used standard score is the _____.
    a. t-score b. z-score c. Percentile rank d. Correlation

11. The scale that distinguishes groups, not reflecting differences in magnitude, is the _____.
    a. Interval b. Nominal c. Tabular d. Frequency distribution

Outcome Studies:

1. Which of the following is not a criteria for evaluating improvement?
    a. Continued medication needs b. Client behavior
    c. Therapist's opinion d. Employment stability

2. Outcome studies which include control groups, a single diagnostic category, and a fixed treatment period are called _____ studies.
    a. Effectiveness b. Descriptive c. Statistical d. Efficacy

3. Which of the following therapist characteristics have been found to be significantly related to positive therapy outcome?
    a. Age b. Race c. Skill level d. Gender

4. Client variables important to positive therapy outcome include _____.
    a. Gender b. Age c. Marital status d. None of the above

5. Premature client drop out is associated with which of the following factors?
    a. Low self-esteem b. Absence of anxiety
    c. Dependency needs d. Depression

6. Studies suggest that the optimum number of treatment sessions has been found to be _____.
    a. 26 b. 8 c. 12 d. 52

Prevention

1. The greater the number of _____ the higher the degree of risk to mental illness.
    a. Cultural stressors b. Risk factors
    c. Traumatic experiences d. All of the above

2. Individual and environmental _____ reduce(s) the risk of mental illness.
    a. Support systems b. Social planning
    c. Systems planning d. Protective factors

3. _____ influence how one grows across the life span.
    a. Cultural norms b. Developmental factors
    c. Family strengths d. Individual strengths

4. Windows of opportunity of prevention interventions can be identified through _____.
    a. Developmental timing b. Developmental factors
    c. Treatment protocols d. Intermediate strategies

5. A planned program of interventions needs to be _____.
    a. Clinically researched b. Strategically placed
    c. Systemically oriented d. Sequentially ordered

6. _____ are an institutional factor in prevention.
    a. Government resources b. Schools
    c. Hospitalizations d. All of the above

7. Sequences in family development and the relationships between parents are what kinds of preventive factors?
    a. Developmental b. Systemic c. Familial d. Relational

Career Development

1. _____ believed in a decision making career development theory.
    a. Roe b. Gelatt c. Super d. Axelrad

2. Four major developmentalists in career development theory are _____.
    a. Axelrad, Ginzberg, Ginsburg, Herma b. Axelrad, Gottfredson, Ginsburg, Herma
    c. Super, Ginzberg, Ginsburg, Herma d. Axelrad, Ginzberg, Hoppock, Herma

3. The three developmental periods of occupational choice progression are _____.
   a. Interest, Exploration, Realization b. Fantasy, Tentative, Realistic
   c. Fantasy, Exploration, Specification d. Consideration, Transition, Crystallization

4. _____'s theory is called Circumscription and Compromise.
   a. Super b. Axelrad c. Gelatt d. Gottfredson

5. _____ created the concept of life-career rainbow.
   a. Gelatt b. Roe c. Crites d. Super

6. Holland's typology fits the _____ based career style.
   a. Decision making b. Developmental c. Personality d. Needs

7. _____ believes that career's are chosen to satisfy our needs.
   a. Roe b. Crites c. Holland d. Axelrad

8. The cognitive model uses the following three basic organizers:
   a. Personality, Life Cycle, Skill Development
   b. Structural, Developmental, Interactive
   c. Personality, Needs, Skills
   d. Life Cycle, Personality, Social

9. Jay Crites coined the term _____ to identify continuous developmental process that move a series of stages and tasks in relation to career development.
   a. Career pattern study b. Career development
   c. Vocational maturity d. Differentiation

10. In the Career Maturity Inventory which three diagnoses are made of the individual?
   a. Differential, Dynamic, Interactive b. Referential, Decisional, Dynamic
   c. Life stage, Personality, Decisional d. Differential, Dynamic, Decisional

Organizational Consulting

1. In organizational consulting consultees have the right to _____.
   a. Feedback b. A contract c. A fair fee d. Informed consent

2. Consultation competencies in organizational development include _____.
   a. Self-awareness b. Industry knowledge
   c. Consulting skills d. All of the above

3. In Caplan's C-Group model _____ encourages members to work as equals.
   a. Clarification b. Collaboration c. Confidentiality d. Consultation

4. In the _____ consultive approach the consultant acts as a coordinator.
   a. Mediation b. Collaborative
   c. Agency Consultation d. Group Consultation

5. Caplan outlined the three levels of a preventive consultation model. The first level includes:
   a. Reduction in risk factors
   b. Reduction in the number of mental disorders
   c. Reduction in the duration of mental disorders
   d. Reduction in the impairment resulting from mental disorders

Professional Practice

1. You are legally bound to work within the _____ of your practice.
   a. Ethics b. Protocols c. Laws d. Scope

2. Before you engage in treatment you must disclose this to your new client.
   a. Specialties b. Liability Coverage c. Preventive Measures d. Fees

3. After how many visits do you need to make a clinical evaluation and treatment plan?
   a. Three b. Five c. One d. Eight

4. When your client's benefits run out, if you do not offer treatment options, you are guilty of _____?
   a. Incomplete Treatment b. Neglect
   c. Abandonment d. Hold Harmless

5. If your client is not making progress you could be guilty of _____ treatment.
   a. Incomplete b. Inappropriate c. Negligent d. Useless

6. When you have another role other than counseling in your client's life you are having a _____ relationship
   a. Collaborative b. Dual c. Therapeutic Alliance d. Consultive

7. One of the most important client's rights is _____.
   a. Vicarious liability b. Informed consent
   c. Accurate record keeping d. Referral and Consultation

8. One of the only times you break confidentiality is when there is a _____.
   a. Break in the frame b. Breach of contract
   c. Duty To Warn d. Written Request

9. Keeping all communications private is the practice of _____.
   a. Informed consent b. Confidentiality
   c. Good practice management d. Duty to warn

10. An exchange of information between two people that is confidential is a _____ communication.
   a. Private b. Clinical c. Therapeutic d. Privileged

11. A person who has not been emancipated is a/an _____.
    a. In-Patient b. Out-patient c. Ward of the court d. Minor

12. Neglect and abandonment of a minor is considered _____.
    a. Negligent parenting b. Child abuse
    c. A felony d. Always an indicator for family therapy

13. Fiduciary abuse, physical neglect, and abandonment are a pattern of abuse toward _____.
    a. Elders b. Children c. Spouses d. Disabled

14. A type of medical clinical note that is often recommended for clinicians is the _____ note model.
    a. SOAP b. WISC c. MEDA d. NCQA

15. How many locks do your records need to be kept behind?
    a. Two b. One c. Three d. Four

16. The abbreviation used to indicate "Diagnosis" is _____.
    a. Dg b. DSM c. Dx d. DD

17. A medication that is prescribed to be taken four times a day is prefaced by _____.
    a. 4x b. 2am-2pm c. FTD d. QID

18. A periodic assessment of the course of psychotherapy is _____.
    a. UR b. CM b. TM d. PES

19. A medication that is prescribed to be taken two times a day is prefaced by _____.
    a. 2x b. BID c. AM/PM d. TTD

20. When a clinician is subpoenaed to court they are considered to be a _____ witness.
    a. Fact b. Expert c. Certified d. Clinical

Mental Health Counselor's Clinical Practice Companion
Continuing Education Program

Study Log

Chapter		Due Date	Date Completed
1	Growth and Development		
2	Personality and Social Development		
3	Assessment		
4	Diagnosis		
5	Treatment Planning		
6	Counseling Theories		
7	Treatment Modalities		
8	Special Treatment Issues		
9	Substance Abuse		
10	Psychopharmacology		
11	Research and Evaluation		
12	Statistics		
13	Outcome Studies		
14	Prevention		
15	Career Development		
16	Organizational Consulting		
17	Professional Practice		

I certify that I have personally completed the Continuing Education Program. I am submitting my self-exam for scoring.

Name

Date

Return with Answer Sheet

Mental Health Counselor's Clinical Practice Companion Continuing Education Program

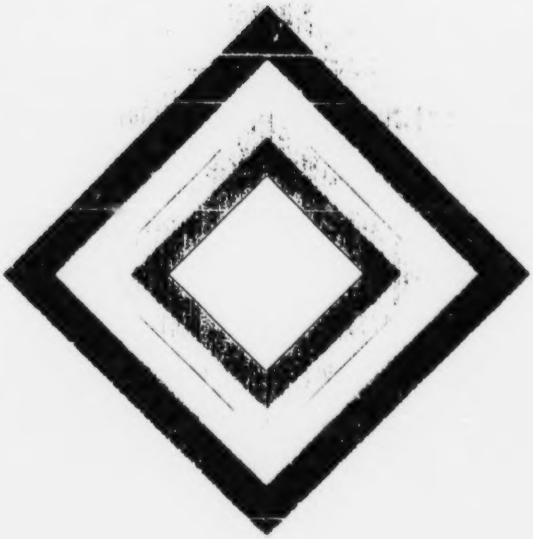
Evaluation Sheet

Please answer each question on a scale from 1 to 5. The scoring scale is defined below:

1 - Not at all 2 - Somewhat 3 - Not sure 4 - Almost completely 5 - Completely

	Question	Score
1	The chapters were written clearly.	1 2 3 4 5
2	The assessment questions tested my knowledge of the content material.	1 2 3 4 5
3	Enough time was allowed to complete the study project.	1 2 3 4 5
4	The study program enhanced my knowledge of the mental health counseling field.	1 2 3 4 5
5	The introduction and directions were clear.	1 2 3 4 5
6	My order was taken in a courteous manner.	1 2 3 4 5
7	My study program was received in a timely manner after my order.	1 2 3 4 5

Return with Answer Sheet



Assessment Questions

ISBN 0-7872-6386-9
90000
9 780787 263867

KENDALL/HUNT PUBLISHING COMPANY
Dubuque, Iowa 52002